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HEALTHAMERICA LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

S. 1227

EXAMINING REFORM OF THE NATION'S HEALTH CARE SYSTEM TO ASSURE ACCESS TO AFFORDABLE HEALTH CARE FOR ALL AMERICANS, FOCUSING ON HEALTH AND ECONOMIC IMPLICATIONS

JULY 24 AND 31, 1991

PART 2

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WEDNESDAY, JULY 24, 1991

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:04 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Simon, Wellstone, Hatch, Kassebaum, Jeffords, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

Our hearing today will focus on the economic impact of S. 1227, the HealthAmerica Act. This is the fourth hearing held by our committee on the bill since it was introduced.

This hearing is particularly important because claims of adverse economic impact are likely to form the heart of special interest opposition to the measure.

I believe this hearing will provide us with a realistic estimate of the true costs and benefits of the HealthAmerica program that will serve as a reliable benchmark for the debate.

In analyzing these costs and benefits from a narrow economic viewpoint, we must never lose sight of the fact that we face a worsening crisis in health care that threatens the well-being of every American family. Too many Americans are uninsured or underinsured, and no family is more than one job loss or one job change, one management decision to cut costs, or one serious illness away from being uninsured.

We must also balance the cost of this program against the cost of doing nothing, which would be the highest cost of all. If we do not act, national spending on health care will soar to $1.5 trillion by the end of this decade, and tens of millions of Americans will pay in the painful coin of economic disaster, ill health and insecurity.

But a realistic assessment of the more narrow economic impact of the bill is also essential, and I believe a fair analysis will show that the part of the program that guarantees health insurance coverage to every American is affordable for American business and the American people and will not have any significant negative effects on economic growth, job creation or employment.

The comprehensive cost containment program included in this bill will not only cover the full cost to our society of extended cov-

erage; it will improve the profitability of American business, stimulate job creation and improve international competitiveness.

I look forward to the careful analysis of this program by the distinguished experts assembled here today.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Our hearing today will focus on the economic impact of S. 1227, the HealthAmerica Act. This is the fourth hearing by our Committee on the bill since it was introduced.

This hearing is particularly important, because claims of adverse economic impact are likely to form the heart of special interest opposition to this measure.

Under these circumstances, it is especially important to weigh the evidence carefully—because wild and misleading claims are common. When we were dealing with the Minimum Health Benefits Bill in the 100th Congress, one widely circulated study claimed the bill would cost the economy $100 billion in additional costs and one million jobs. This study was thoroughly discredited by impartial experts testifying before the Committee. They found the study fundamentally flawed and concluded that any negative economic impact of the program would be minimal.

In a similar case, the Chamber of Commerce analyzed the Family and Medical Leave Bill and claimed that it would cost business $27 billion. But a few weeks later, the non-partisan and respected Congressional General Accounting Office released an analysis indicating that the cost would be $500 million, two per cent of the what the Chamber of Commerce claimed.

I hope that this hearing will provide us with a realistic estimate of the true costs and benefits of the HealthAmerica program that will serve as a reliable benchmark for the debate.

The HealthAmerica legislation is a comprehensive program to respond to the worsening crisis in health care that threatens the well-being of every family. The first part of this unprecedented crisis is the large and growing number of uninsured and underinsured Americans. Too many Americans are without any health insurance whatsoever. Even families with insurance can no longer be certain that it will be there to protect them when they need it most.

The second part of the crisis is out-of-control costs that threaten to price health care beyond the reach of the average American family and that burden American businesses struggling to compete in international markets.

Two decades ago, the number of the uninsured was falling every year. Today, a shocking 33 million of our fellow citizens have no insurance—and the number is rising every year. Sixty million more Americans have insurance that even the Reagan Administration said was inadequate.

The sad fact is that no American family is more than one pink slip, one job change, one management decision to cut costs, or one serious illness away from being uninsured.

Health care is the fastest growing failing business in America. Since 1980, per capita costs have more than doubled. If costs con-

inue to rise at current rates, health insurance for the average worker will cost more than $15,000 by the year 2000.

Today, we pay 40 per cent more per person than Canada, and wice as much as Germany or Japan.

The high cost of health care is a major problem for American corporations struggling to compete with the rest of the world. For example, the price of each Chrysler Corporation car that is produced includes $700 worth of health care, compared to only $200 to $400 for every Japanese car. Today, health care costs paid by American business are actually higher than after-tax profits. As a result, as businesses cut back on costs, American families often find that the health insurance they get on the job is covering less and less of their typical medical bills.

HealthAmerica attacks these problems head-on by guaranteeing every American affordable health insurance coverage, and by establishing a comprehensive program to control health care costs.

Under the program, coverage will be provided on the job or through a new Federal-State public insurance program called "AmeriCare". Employers will have a choice—either provide coverage meeting basic standards to workers and dependents, or else contribute to AmeriCare coverage for their employees by paying a per-cent of payroll, currently expected to be seven or eight per cent. The unemployed will also receive coverage through AmeriCare, with premiums based on ability to pay.

HealthAmerica's cost containment program deals with all four parts of the cost problem: Cost shifting, unnecessary care, excessive administrative costs, and blank-check reimbursement to providers. It is estimated to save close to $90 billion over the next five years.

In the debate on this proposal and on earlier plans putting requirements on employers, concerns have been raised about the economic impact of the plan. These include questions about the effect on small business, about the impact on industry's ability to compete in world markets, and about the overall effect on jobs and economic growth. As our hearing today will demonstrate, there are good answers to these questions.

A majority of small businesses already provide coverage to their employees. But they are struggling under the burdens of excessive cost inflation and a small business insurance market that charges too much for its product and does not guarantee the availability of coverage or stability in costs.

HealthAmerica is tailored to the special needs and concerns of small businesses. The opportunity to contribute to AmeriCare rather than provide direct coverage is a significant savings for many small businesses already providing coverage and for those who will assume this responsibility under the new program. For example, the cost of providing coverage directly for a single employee working at the minimum wage is approximately $1,000. By contrast, the contribution to AmeriCare for that same employee would be only $600—less than $3 a day.

Small businesses that choose to provide coverage directly are eligible for additional assistance. A new tax credit will cover up to 25 per cent of the cost of coverage. Coupled with existing tax exclusions, tax benefits will cover approximately half the cost for small businesses receiving the full credit.

Self-employed owner-operators of unincorporated small businesses will be allowed to deduct 100 per cent of the cost of the health insurance they buy for themselves and their families. Today, they can only deduct 25 per cent.

Small businesses that have not previously insured their employees will be allowed to buy coverage that pays providers at Medicare rates, a substantial discount over current costs.

HealthAmerica will also be phased in for small firms in order to give them time to adjust. If small businesses together, on a national basis, voluntarily reduce the number of uncovered workers by 75 per cent, the requirement to provide or contribute to coverage will not apply to any individual firm.

Equally important, our plan will reform the small business insurance market to move it closer to a community-rated system. Every small business will be guaranteed the opportunity to purchase health insurance coverage at a fair price, and administrative savings and greater competition will reduce premiums by 10 per cent.

Senator Hatch.

Opening Statement of Senator Hatch

Senator Hatch. Thank you, Mr. Chairman.

Mr. Chairman, there are a number of ideas on how to expand access to health care. There are many ways, and many of them have broad negative economic implications.

Today's focus will be to understand the economic impact of the "Mitchell mandate". For many years, I have talked to employers, workers, health care experts and others about the costs associated with mandating health insurance upon employers. The "Mitchell mandate" merely repackages these costs by adding an additional wrinkle; that is, if an employer doesn't provide an approved package of benefits, then they must pay a tax.

Mr. Chairman, this plan, no matter how it is packaged, is still an employer mandate. Such a plan threatens the survival of many small businesses in America. This proposal will cost jobs, and just one of the consequences of no job in this country is no health insurance.

It is my hope that all witnesses today will provide the committee with their best estimates of the impact which an 8 percent payroll tax will have on the loss of current jobs and the limitations on new job creation. Three-quarters of all new jobs created over the past decade are in the small business sector.

Mr. Chairman, I understand that you and Senator Mitchell have given the proposal a $6 billion price tag. Without question, there are many who disagree with that estimate, and there are others who may question the reliability of the predictions. I am particularly interested in the assumptions and variables that have been built into these models and the degree to which variances in these assumptions lead to dramatic increases in the estimates.

There remains some controversy over the threshold average wage amount per employer that is likely to trigger a "pay" rather than "play" option. I have reviewed some estimates that as many as 60 million individuals could be cast off from employer-provided insurance programs to the public insurance programs—public pro-

grams that are already choking under the strain of high cost and high expectations and for which no resuscitation is proposed in this legislation.

I will ask our panel to provide their own estimates on the number of citizens who will lose the flexibility of employer-provided insurance. I cannot imagine that the number would be insignificant.

Finally, this bill begins Federal rate regulation through so-called "national expenditure targets". I will ask our experts what evidence they have or what hope they can fantasize that rate regulation will work in this country. Independent of the hopelessness of rate regulation as an economic model, I believe that this is a backhanded way for the Federal Government to impose rationing. Nothing could be more destructive in my opinion than to begin rationing from Washington. It is wrong; it will not work. It deprives people of choices.

So I will continue to oppose the "Mitchell mandate" because of its broad negative economic consequences. It will result in lost jobs, lost wages, and will harm low-wage workers the most. It will not help us to provide quality health care in the long run.

I believe, having said that, that it is important that we hold these hearings so that we can look at all these things, because what at least some think are simple explanations always turn out to be very complex. And maybe in the holding of hearings and listening to our experts and to those who have special needs and interest in this area, we might be able to find some way to resolve the health problems of this country and the health insurance problems of this country in a good and reasonable way. I suspect we'll have some witnesses here today who will have some very interesting and intelligent ideas on this.

Thank you, Mr. Chairman.

The CHAIRMAN. I'm glad to see you are so open-minded.

Senator HATCH. Well, it has only taken me 15 years to reach this conclusion, but I'm still going to keep an open mind.

The CHAIRMAN. Before recognizing Senator Wellstone, I am mindful of the *New York Times* article about Hawaii yesterday. Hawaii has a completely mandated program and has the lowest cost of health care of any State in the country, and has the lowest unemployment, and they have been doing it for 17 years.

Senator HATCH. Well, then, maybe we ought to apply the Hawaii plan to all of America.

The CHAIRMAN. Will you sign on it? Do you want to sign on it now? That is a fully mandated program, Senator. If you want to take that right now, we'll go over and put it in this afternoon. [Laughter.]

Senator HATCH. I have to say, with that kind of an explanation, who wouldn't take it?

The CHAIRMAN. The Senator from Minnesota.

OPENING STATEMENT OF SENATOR WELLSTONE

Senator WELLSTONE. Thank you, Mr. Chairman.

Mr. Chairman, the goal of HealthAmerica is universal access to health care. I am fully committed to making that goal a reality.

I have some different thoughts about how to achieve universal access, but I am confident that as a party, as a Congress and as a Nation, we can work together to ensure that all Americans have access to affordable, dignified, humane health care. That is our goal.

Access to health care ought to be a right of every citizen regardless of their income, and we have heard testimony about that; regardless of employment status, and we have heard testimony about that; and regardless of current health care condition or age, and we have heard powerful testimony about all of that.

For too long, Washington has ignored the voices of people all across this country who are demanding change. But I think we have reached the time now where Washington can no longer ignore those voices. In every town I have visited in Minnesota, every cafe—and I don't think I am exaggerating to say every street corner—people are talking about health care more than any other issue.

Now, in Washington, DC—and I want to point out this discrepancy—on the one hand, to use "Fiddler on the Roof" for a moment, people in Minnesota and other States are talking about health care as the most pressing issue right now in their lives. On the other hand, what I hear in Washington is that so-called political realities mean that we can't really pass legislation that will bring about universal health care.

Can we make universal access to health care a reality? I think the reality is we have no other choice. It is time for decisionmakers in DC to listen to all the personal stories and the collective voices of people all across this Nation who are calling for change.

Mr. Chairman, I think there is one aspect of this crisis more than any other aspect that unites all of us. That is the astronomical increase in health care costs. This is what brings us together. What began as a crisis which affected poor people has swept into the middle class, has affected the business community, and I think is building a very broad base of support for major change. And it will be this issue of the dramatic increase in costs of health care and the potential to control these costs which I think will drive the debate and I think will also drive the reforms.

We spend more than 12 percent of our gross national product on health care, but what is even worse is that 25 percent of what we spend on health care goes to billing and administration, not in actually providing care for people.

These are economic costs that we cannot bear, and there is a terrible price. We have had hearings, and we have heard about that price—the 33 million people who are without insurance—double that number who are underinsured—the business community, you name it.

I think, therefore, we need to examine the ever mounting evidence of the potential savings and costs that would come from a single payer system, and I hope that will be part of our discussion on this committee.

I want to bring to everyone's attention a recent General Accounting Office study——

The CHAIRMAN. Senator, I hope you'll do it briefly, because we are going to have votes all morning, and we want to hear from our witnesses.

Senator WELLSTONE. I will be very brief. I just have a couple more minutes. I'm going to keep in the same spirit of your statement and Senator Hatch's and keep it to under 5 minutes.

I'd like to bring to everybody's attention the General Accounting Office study, which pointed out that we could save $67 billion in 1 year from a single payer system. I think that this is a study that deserves a lot of attention. I want to quote from this study: "$67 billion in 1 year and substantial further cost savings in the years to follow".

Mr. Chairman, I want to point out that we can and we must have serious cost control as we move toward universal access to health care. The bill introduced by the Democratic leadership moves us toward these goals, but I think we have to do more to ensure access, more to ensure affordable care, more to contain costs, and more to simplify and streamline our health care system and more to encourage preventive health care.

I think we will have the change, Mr. Chairman. I think that we can build the most efficient and equitable health care system in the world. I think that that is a goal we can reach.

I look forward to the testimony today that zeroes in on the economic impact of this leadership bill, and again, as we move forward in our discussion and in our dialogue, which I think is a very important discussion, I also want us to focus in on the whole question of cost containment and the potential of a single payer system, along with other proposals that are before us.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Our first panel consists of a group of distinguished economists who are also health policy analysts. Professor Karen Davis, chairman of the Department of Health Policy and Management at Johns Hopkins School of Public Health, is former deputy assistant secretary for health planning and evaluation, Department of Health and Human services.

Ken Thorpe is an associate professor in the Department of Health Policy and Administrative at University of North Carolina.

Dr. Stuart Butler is the director of domestic and economic policy studies at The Heritage Foundation and one of the key authors of the Foundation's universal health care proposal.

We are delighted to have all of you. None of you are strangers to those of us who have been wrestling with this problem for many years. We always benefit from your testimony, and we admire the fact that you have held responsible positions in various administrations over a long period of time and continue to be involved in public policy issues and questions.

We are delighted to welcome Karen Davis back and look forward to your testimony.

STATEMENTS OF KAREN DAVIS, PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH, BALTIMORE, MD; KENNETH E. THORPE, ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH POLICY AND ADMINISTRATION, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC; AND STUART M. BUTLER, DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Ms. DAVIS. Thank you, Mr. Chairman and members of the committee, for this opportunity to testify on the health and economic implications of the HealthAmerica proposal to provide universal health insurance coverage to all Americans at an affordable cost.

I'd like to just highlight a few points for the committee this morning. I think the Nation needs to move forward and cannot tolerate any longer the hardship imposed by a health system that leaves 33 million Americans uninsured, 60 million with inadequate health insurance and virtually all Americans at risk of being unable to afford decent health care if they lose their jobs or become seriously ill.

The HealthAmerica plan builds on the American tradition of a combination of employer-provided health insurance and coverage for workers and their families, and public plan coverage for those requiring special assistance.

This plan has many innovative features, and I'd like to mention a few of those this morning. One of the most innovative features of HealthAmerica is that it gives employers the choice of enrolling workers and their families in their private health plans or in a public plan. They pay a premium if they choose private insurance and pay a payroll tax of about 7 percent if they prefer to cover their workers and dependents under a public program. This makes coverage much more affordable to low-wage firms. It is a much more progressive way of financing care by giving them the option of paying a payroll tax which is a fixed percentage of earnings. It eliminates the administrative burden on a small firm of trying to find private health insurance if they prefer public plan coverage and gives them the option of enrolling workers in a public plan where administrative expenses under Medicare and Medicaid, as Senator Wellstone has referred to, run only 2 to 3 percent of benefit costs. So it would greatly improve the situation where now half of the working uninsured work in firms with fewer than 25 employees.

The feature of the plan that would permit other individuals to be covered under the public plan also is very attractive. Employers could cover part-time workers, for example, under the public plan. Temporary/seasonal workers and unemployed workers could be covered under the public plan. This would help reduced turnover in that somebody who was only temporarily attached to the work force or unemployed or low wage would probably continue under the AmeriCare public plan.

It is also a big improvement in Medicare because it lets early retirees under age 65 get into the public plan coverage; it lets disabled individuals who may be in the two-year waiting period for

Medicare be covered under a public plan; spouses of Medicare beneficiaries could also be covered.

Another attractive feature of HealthAmerica is the reform of the private health insurance market. We have seen a deterioration in private insurance practices, underwriting practices that exclude people with pre-existing conditions or have long waiting periods. Those would be eliminated. In effect the reforms would eliminate many of the worst abuses in the small employer insurance market and forestall even greater trends toward denying coverage to high-risk individuals.

The plan is also an important improvement over the current Medicaid program, which would be replaced, at least for acute care benefits, with the new AmeriCare plan. Furthermore, this would cover all poor persons without charge and provide on a sliding scale subsidies up to twice the poverty level and reverse some of the deterioration in the Medicaid program that has occurred over recent years.

HealthAmerica also contains a number of innovative features to encourage efficiency. It would set up a health expenditure board to establish prospective expenditure targets and the negotiation of provider payment rates. Certainly, what we have learned from other industrialized nations is that the most compelling way in which costs can be effectively contained is to have this type of strong government role in setting or negotiating provider payment rates and particularly those that are subject to expenditure targets or ceilings.

Other provisions would try to control costs through expanded effectiveness research, data systems, physician profiling, and other measures that could also be expected to contribute to costs.

Finally, the feature of the plan that would phase in benefits over time I think is very important, starting with our Nation's children, to make sure we are making an investment in getting babies off to a healthy start in life.

I'd like to comment a little bit on the economic implications of HealthAmerica. We are really talking about fairly modest changes in current sources of financing. Estimated impact on the total health system is around $18 billion. We are talking about spending over $600–$700 billion now. That is really adding less than 3 percent to total health spending, and obviously with cost containment measures, one could reduce that. But that is the effect of new services that would be covered.

There are only marginal changes in current sources of financing. You really could not expect this plan to have much of an inflationary effect. There is a lot of excess capacity in the health industry, with lower hospital occupancy rates, for example.

Senator Hatch particularly wanted our estimates on the impact of employment. I think one of the nice features about this bill is that it limits the maximum employer contribution to 7 percent of payroll. I think there was some criticism of earlier bills that had a flat premium so that for a worker working 20 hours, it might be a big percentage of labor cost. This is really quite modest. Applying the latest econometric studies, at most you are talking about a 50,000 job loss in a nation which has 120 million or so jobs. Particularly in a dynamic labor market, where you are always adding new

jobs, you are unlikely to see any effect, and as Senator Kennedy pointed out, in Hawaii, that has had such a mandated system for 17 years, they have a very low unemployment rate. And I might just add to his statistics also, a very low infant mortality rate. They have done a very good job about prevention in their system.

The other point is that the labor market is a tight one. That is also what is happening in Hawaii. Drops in fertility rates in the mid-1960's means that there aren't as many people entering the labor force. Many employers are going to have to provide benefits to attract workers.

The other point that people overlook is that this bill will add jobs in the health industry. We will be providing new services to the uninsured, and that takes people. We think of physicians, but there are laboratory technicians, all kinds of people, who provide services. So it is usually the case that any new spending bill is expansionary for the economy, and this bill would be no different even if the bulk of it is coming through private insurance.

It is very important for health care. It would cover the 33 million uninsured, would have good coverage of preventive services, particularly prenatal delivery and well child care, but also mammography, Pap smears, and other important preventive services would be covered.

In summary, the plan both as a comprehensive package and the particular innovative improvements in existing programs gives much to its benefit. It would represent an equitable sharing of the burden of the cost of financing health care among large and small employers, among workers and Federal and State governments. It builds on our existing administrative expertise both in the private insurance industry and the government sector. It brings about much needed health system reform measures. It emphasizes prevention and primary care.

Nor is it likely to cause major economic dislocations, employment loss from higher labor costs would be quite modest, and expansionary impact on the health industry could be accommodated since we're really talking about only a 3 percent increase in the kinds of services that would be provided.

I think the most important point is that we simply cannot afford to do nothing. We can't afford to waste the health and productive capacity of our people by failing to invest in adequate health care for all.

I thank the committee for this opportunity to appear and urge that you assume the leadership necessary to make this plan a reality for the benefit of all Americans. Thank you.

The CHAIRMAN. Thank you very much, Ms. Davis.

[The prepared statement of Ms. Davis (with attachments) follows:]

PREPARED STATEMENT OF MS. DAVIS

Thank you, Mr. Chairman, for this opportunity to testify on the health and economic implications of the HealthAmerica proposal to provide universal health insurance to all Americans at an affordable cost. The Nation can no longer tolerate the hardship imposed by a health system that leaves 33 million Americans uninsured, 60 million with inadequate health insurance, and all virtually Americans at

risk of being unable to afford decent health care if they lose their jobs or become seriously ill.

The HealthAmerica proposal has much to commend it. It would build on our existing system of employer-provided health insurance—closing the gaps in coverage by requiring all employers to either provide private health insurance or pay a payroll tax toward coverage of workers and dependents under a new public health plan. It distributes the financial burden of care more equitably among employers and among individuals by giving everyone the option of coverage under a public plan where contributions are based on earnings or income. It makes health care affordable to everyone—including low-wage firms and individuals with modest incomes or serious chronic health conditions.

Today, I would like to review the health and economic consequences of this approach to assuring universal health insurance coverage, as well as discuss how the cost of health care would be distributed under the HealthAmerica plan. The economic consequences, including any potential effect on employment, of the plan deserve careful consideration and I am pleased to share with the Committee my own analysis of this aspect of the plan.

The HealthAmerica Plan

The HealthAmerica plan builds on the American tradition of a combination of employer-provided health insurance coverage for workers and their families and public plan coverage for those requiring special assistance. Building on this structure, it proposes a fundamental strengthening and integration of our mixed private-public system of health insurance coverage to guarantee coverage to all Americans. There ore many innovative features of this plan which I think deserve special attention.

Employer Choice of Private or Public Insurance Coverage

One of the most innovative features of HealthAmerica is that it gives employers the choice of enrolling workers and their families in either private health plans or in a public plan. Those employers who currently have private health insurance coverage that adequately meets the needs of workers and families would be unaffected. However, those employers who find it difficult to obtain good private health insurance at a reasonable cost would have the option of simply paying a payroll tax to ensure coverage of workers and dependents under a public program.

This employer choice approach has several advantages. It makes coverage more affordable for low-wage firms—by limiting the maximum liability to a percentage of payroll such as 7 percent. This contribution would be known with certainty, would be predictable over time, and would be more affordable for a low-wage firm than a premium contribution covering the full actuarial cost of coverage. It eliminates the time and administrative burden for a small firm to find a private health insurance plan, and gives firms the option of enrolling in a public plan whose administrative expenses typically run only two to three percent of benefit costs—contrasted with 20–50 percent administrative costs built into many small firm health insurance premiums.

Public Plan Coverage Option

The public plan coverage option would also be extremely important to those outside the workforce or not strongly tied to the work force. Employers could cover parttime, temporary, and seasonal workers who are in and out of the workplace under the public plan. Unemployed workers could continue their coverage by picking up the premiums based on their ability to pay.

Most importantly, retired individuals or other non-working adults under age 65 would have the opportunity of buying-in to a public plan before age 65. It would also improve coverage for those disabled individuals who now must wait at least two years for Medicare coverage. Spouses or widows of Medicare beneficiaries who are under 65 do not qualify for Medicare. Such individuals could purchase coverage with subsidies for those with incomes below 200 percent of poverty. This is an extremely important feature and should be considered for early implementation. Alternatively, Medicare coverage could be expanded to early retirees age 60 and over and the waiting period for the disabled could be shortened or eliminated.

Insurance Market Reform

Another attractive feature of HealthAmerica is the proposed reform of the private health insurance market. This market is becoming increasingly selective—with in-

surers declining to cover individuals viewed to be poor health risks or instituting restrictions or waiting periods for pre-existing conditions. Small businesses, in particular, risk having their coverage dropped if a worker or family member gets ill, or have certain individuals excluded from coverage, or find premiums raised to exorbitant levels.

Under HealthAmerica, private insurance plans could not exclude individuals or pre-existing conditions. It would require that the same coverage be offered to all firms on the same terms. A voluntary reinsurance mechanism for high-risk individuals would be established. These changes would go far to curb the worst abuses in the small employer insurance market, and forestall even greater trends toward denying coverage to high risk individuals.

Medicaid Reform

The plan would replace the current Medicaid program with MediCare, a universal low-income entitlement program that is not tied to the welfare system. All poor persons would receive coverage without charge under this new federal public plan. Near-poor persons would be covered on a sliding scale basis.

AmeriCare would reverse some of the deterioration in the Medicaid program that has occurred as the result of budgetary cutbacks in the 1960's. Over time physicians and hospitals would be paid at Medicare payment rates—replacing the substandard Medicaid payment rates but incorporating the cost containment and efficiency incentives of Medicare. This should encourage greater provider participation and reverse the trend toward refusing care to Medicaid beneficiaries.

Coat Containment and Health System Reform

HealthAmerica also contains a number of innovative features to encourage efficiency in the health care system. The establishment of a Health Expenditure Board to establish expenditure targets for physician, hospital, and other services is an especially important feature. Negotiation of provider payment rates within this system could form the basis of a more equitable and efficient system of provider payment.

The one lesson from the experience of other industrialized nations that is most compelling is the effectiveness of cost containment in those systems with a strong government role in setting or negotiating provider payment rates. The plan is a significant step toward such an approach.

Other recommendations that include support for effectiveness research, data systems including physician profiling and practice patterns for care of all patients not just Medicare beneficiaries1 choices of managed care systems, funding of prevention, health education, outreach1 and primary care, and quality assurance mechanisms are also extremely important.

Phasing

The plan would begin by insuring all our nation's children. This phasing places top priority on investing in the health of future generations by immediately assuring universal coverage of pregnant women and young children, with complete coverage of prenatal, well-baby care, and other preventive services such as Pap smears and mammography.

Coverage of working families begins with larger firms. Smaller firms would be phased in only after such companies have adequate time to provide coverage voluntarily and only if coverage targets are not met voluntarily.

This phasing enhances both the economic and administrative feasibility of the plan. It gives employers opportunity to plan for coverage of workers, and subsidizes the start-up of coverage by firms. It would give employers time to make adjustments in total compensation packages to minimize unemployment and economic disruption effects.

Another advantage of the phasing approach is that it permits mid-course corrections to be made if economic conditions change or if the demands on the federal budget or health system should prove different than anticipated. Subsequent phases can be delayed or accelerated, for example, if initial cost estimates prove high or low. Experience with the cost-containment provisions can indicate whether more stringent measures are required, or whether private and public plans are building on the best elements of managed care and provider payment currently incorporated in Medicare and employer plans. Coverage of an initial set of preventive services will provide evidence of the desirability of a broader preventive care benefit package.

Economic Cost of HealthAmerica

The HealthAmerica bill could be expected to have a modest incremental economic cost. Total new health system cost is estimated at $18 billion when fully implemented.

These outlays are modest given the current size of the health care sector. In 1989, national health expenditures were $604 billion, of which over $233 billion came from government, $125 billion came from consumers directly out-of-pocket, $200 billion came from private health insurance payments, and the remainder from miscellaneous private sources.

Viewed from this perspective, the proposed bill would add about three percent to total outlays for health care and make only marginal changes in current sources of financing. These are not revolutionary shifts in health outlays and could be expected to have only modest effects.

From the perspective of the uninsured, however, the plan would provide health insurance coverage for 33 million uninsured Americans, remove the financial obstacles to obtaining health care for children, pregnant women, and those with chronic health problems, avoid postponing care for serious health symptoms such as bleeding or loss of consciousness, and lift the crushing financial burden a serious health problem can inflict.

Inflationary pressure from the new expanded pressures can be expected to be minimal. The health sector is currently experiencing serious excess capacity—both in terms of low hospital occupancy rates and a significant increase in the supply of physicians. New health care services by those who are currently uninsured could be accommodated easily within the current system without generating inflationary pressures.

Impact on Employment

The employment effects of HealthAmerica can be expected to be quite modest. The option of buying public plan coverage by paying a payroll tax such as 7 percent of earnings guarantees employers that increases in labor costs can not exceed this modest amount. Coverage is phased in permitting small employers time to make corresponding adjustments in wages and other fringe benefits. In theory one would expect employers to shift costs in the longer term to workers, resulting in lower wages than would otherwise have been paid. The exception to this is those workers at or near the minimum wage where the employer could not legally lower wages.

However, the maximum employment effect for firms with low wages near the minimum wage is quite marginal. Using recent estimates from studies of the employment effect of increases in the minimum wage, a seven percent increase in labor costs can be expected to reduce employment by loss than 0.35 percent. Applied to an estimated 4 million low-income uninsured workers and 12 million low-income workers insured under other employer plans, this would yield an estimated job loss of less than 50,000 jobs, which would add less than 0.05 percentage points to the unemployment rate. This is a very small change in the context of a dynamic labor market which is continually generating new jobs.

Other factors suggest that any adverse effect on employment would be even less. The labor market for entry-level workers is tightening with the drop in fertility in the mid-1960's leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely. The types of jobs that are potentially affected are largely in the service sector or retail trade which are not as sensitive to international competition.

Most importantly, the additional health services received by the uninsured under this plan would in itself have an employment stimulating effect. The increased utilization or health services by the uninsured could be expected to add jobs in the health sector. The net employment impact of the bill, therefore, may be positive rather than negative. This should not be surprising since most new "spending" programs are expansionary rather than contractionary1 even when financed by additional revenues.

Implications for Health Care

This plan would add 33 million more people to health insurance coverage. This would provide much needed improvement in access to health care for a largely low-income population. Maternity and infant care services would be covered without cost-sharing for those covered. Improved access to acute care for the uninsured would improve health and give children a better chance at productive lives. The plan would help reduce the intolerable delay in obtaining needed health care for

pregnant women, children, those with chronic health problems such as hypertension and diabetes, and those with life-threatening symptoms such as bleeding, chest pain, and loss of consciousness which many uninsured now experience.

Summary

In summary the plan both as a comprehensive package and as innovative improvements in existing programs has much to commend it. It represents an equitable sharing of the burden of the cost of financing health care among large and small employers, among workers, those able to afford to contribute individually to their own coverage, and federal and state governments. It builds on the administrative expertise in the private health insurance industry, while eliminating practices that have made health insurance unaffordable for many businesses. It institutes many much needed health system reform measures to curtail rising health care costs, and shift the emphasis in our health system toward prevention and primary care. It moves immediately to address our underinvestment in the health of our children.

Nor is the impact of the plan likely to cause major economic dislocations. My own estimates indicate that any employment loss from higher labor costs would be quite modest. These losses would be more than offset by the expansionary impact on the health industry—which would expand to provide much needed health care to currently uninsured individuals.

The cost of expanded health services for the uninsured would lead to a total increase in health spending of about three percent of current national health expenditures. With the expanding supply of physicians and hospital occupancy rates at record low levels, this new demand for health services should be easily accommodated without inflationary pressures.

While the cost and economic impact would be small relative to our nation's economic resources, the improved access to health care services would have a major impact on solving one of our nation's most pressing social problems. We are the only major industrialized nation that denies needed health care to its citizens because they are unable to afford such care. We can not afford to waste the health and productive capacity of our people by failing to invest in adequate health care for all.

I thank the committee for this opportunity to appear today, and urge that you assume the leadership necessary to make this plan a reality for the benefit of all Americans.

COMMENT ON CONSAD RESEARCH CORPORATION REPORT ON JOBS-AT-RISK

Summary

The report Jobs-at-Risk by Consad Research Corporation published on October 1, 1991, is a seriously flawed analysis of the job loss associated with mandated employer health insurance. This report uses unsubstantiated assumptions which render the findings and conclusions of the report invalid and completely lacking in merit.

The report defines the term "jobs-at-risk" to include all uninsured workers with incomes below a very high threshold. It could just as easily be coined "workers-who-stand-to-benefit" by employer provided health insurance. The term has no economic meaning, and in no way are the jobs of the workers so characterized in any way at risk.

The report also uses an unsubstantiated assumption about the impact of new health insurance premiums on job loss. The report simply asserts that an 8 percent increase in labor costs caused by a health insurance premium is assumed to result in a 50 percent loss in jobs. This is totally out of line with estimates from the minimum wage literature that suggest that an 8 percent increase in the minimum wage would have less than a 1 percent impact on jobs. If the author's assumption were correct, a 30 cent increase in the minimum wage would lead to the loss of half of all minimum wage jobs. This is totally contradicted by all experience. The computer simulation results and conclusions based on this assumption are totally invalid.

Definition of "Jobs-at-Risk"

The report purports to analyze the impact of the Basic Benefits for All Americans Act, S. 768. Most of the report is centered around tables with counts of "jobs-at-risk" with estimates of such jobs by state, Congressional district, size of firm, and industry. The report defines "jobs-at-risk" as any uninsured worker for whom the mandated premium represents more than two percent of average annual wages. The premium used in the model is about $1,360 for a single individual and $3,390 for a

family (based on mid-point of geographic range in footnote 5 on p. 54). Therefore, by definition "jobs at risk" are any uninsured single worker with annual earnings below $68,000 and any uninsured married worker withannual earnings below $169,500—i.e. those workers for whom the premium is at least 2 percent of income. Since most uninsured workers have incomes below these threshold levels, the count of "jobs-at-risk" is really just the count of uninsured workers who would receive health insurance under the mandated employer plan. This can be seen on p. 15, for example, where Table 3.3 shows that under Option 3 (the most comprehensive mandate option) the number of newly covered uninsured workers is 8.9 million (12.5 million uninsured currently in column five less 3.6 million uninsured under mandated coverage in column 6) and the total number of "jobs-at-risk" is 8.6 million. In other words virtually all uninsured workers who would be affected by the plan are simply defined to be "jobs-at-risk." One could just as easily have titled the report as "Workers-Who-Stand-To-Benefit" and presented all of the tables by state and Congressional District as the number of uninsured workers who would be provided with employer-based health insurance that they can not easily afford to purchase individually. To label such uninsured workers as "Jobs-at-Risk" implies that they will be unemployed as a result of getting health benefits—which is hardly the case.

Assumptions Regarding Job Loss

The fatal flaw of the report is the assumption used to estimate loss of jobs presented on the last page of the technical appendix (p. 58). Here the report simply assumes that 50 percent of workers for whom the premium is greater than 8 percent of wages, or single uninsured workers with incomes below $17,000 and married uninsured workers with incomes below $42,375, will lose their jobs. Substantial job losses are also assumed for workers for whom the health insurance premium is between two and eight percent of earnings (i.e. uninsured single workers with incomes between$17,000 and $68,000 and uninsured married workers with incomes between $42,375 and $169,500).

No rationale or economic study is cited as the basis for these extraordinarily high rates of job loss assumptions. They are totally out-of-bounds with anything reported in the minimum wage literature. For example, Brown, Gilroy and Kohen (BGK) using data for the 1960's and 1970's found that a 10 percent increase in the minimum wage "suggests that 1 percent is a reasonable 'single number' estimate of the employment effect." (Brown, Gilroy, and Kohen, 1983, p. 38) Solon made a technical improvement to adjust for seasonal effects in the BGK model and using data prior to 1980 found that a "10 percent increase in the minimum wage (or its coverage rate) is associated with about a 1 percent decrease in teenage employment." (Solon, 1985, p. 297) Wellington reestimated the BGK model using more recent data from 1954 to 1986 when labor markets were considerably tighter due to the drop in birth rates in the mid-1960's. (Wellington, 1988) She found that a 10 percent increase in the minimum wage is associated with a 0.56 percent decrease in teenage employment opportunities. She further found that a 10 percent increase in the minimum wage is not associated with any significant employment effect on young adults. Luskin, an economist at a the U.S. Department of Labor, used data through early 1984, found that a 10 percent increase in the minimum wageis associated with a 0.2 percent decrease in teenage employment opportunities; but even this change is not statistically significant. (Luskin, 1984) A critique of these and other studies is contained in Isaac Shapiro, "The Minimum Wage and Job Loss," Center on Budget and Policy Priorities, July 1988.

Therefore, the best estimates of job loss using the most recent data, find no job loss for adults, and less than an 0.5 percent job loss associated with a 10 percent increase in minimum wages for teenagers. Applying these results to an 8 percent increase in labor costs from health benefits would imply a 0.4 percent loss in jobs for teenagers—not a 50 percent loss in jobs for all uninsured workers.

If the report's assumptions are right, a 28 cent increase in the minimum wage from $3.55 to $3.83 (i.e. an 8 percent increase) would have eliminated 50 percent of all minimum wage jobs. Yet, the minimum wage was recently increased from $3.55 to $4.25 without any detectable reduction in minimum wage jobs.

Therefore, the assumptions underlying the computer simulation model in this report, are simply without any economic foundation or empirical validity and totally without merit. To simply make such extraordinary assumptions and bury them in a technical appendix of a lengthy report with numerous tables showing counts of "jobs-at-risk" and employment losses is irresponsible.

General Comments

The report is based on an employer-mandated health insurance plan that requires employers to purchase private health insurance and pay an actuarial premium for such coverage. The job effect associated with such a plan is dramatically different from employer "play or pay" plans such as S. 1227 sponsored by Senator George Mitchell (D.-Me.) and other Democratic Senators. Under S. 1227 all employers have the option of covering workers and dependents under a public plan by paying a 7 percent payroll tax. Therefore, no employer will ever experience an increase greater than this amount. This substantially reduces the cost to employers of low-wageworkers and part-time workers, and substantially lessens any potential employment effect.

The premium used in the model substantially exceeds the premium estimated by the Congressional Budget Office of the mandated employer health insurance plan. CBO, using an actuarial analysis by Actuarial Research Corporation, estimated the premium at $642 for a single worker, $1,631 for a married worker, and $1,186 on average per worker. By contrast, CONSAD assumes $1,360 per single worker and $3,390 per married worker—100 percent greater than the CBO estimates.

The CONSAD report asserts that the plan would reduce economic growth, increase inflation, and generate business failures. No evidence is given for this assertion. Macroeconomic models by Wharton and others have found negligible effects on economic growth and inflation.

The report repeatedly asserts that the plan will hurt the very people it is intended to help. The report does not provide any proof of this assertion, and contains no analysis of the health benefits of the plan and its impact on improved access to health care and preventive services. The report asserts that the largest beneficiary will be the "medical community" implying that expanded coverage will simply benefit physicians. There is no evidence to support this assertion.

The report neglects the employment effect on the health industry. CBO estimated that the plan would increase health services received by the uninsured or inadequately insured by approximately $15 billion. This will require an increase in jobs in the health industry of approximately 100,000 to 120,000 to provide such expanded health care to the underserved.

References

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COMMENT ON MONHEIT AND SHORT ARTICLE ON "MANDATING HEALTH COVERAGE FOR WORKING AMERICANS"

Summary

Alan C. Monheit and Pamela Farley-Short published an article "Mandating Health Coverage for Working Americans" in the journal *Health Affairs* in Winter 1989. This article provides an estimate of the employment effect of the Minimum Health Benefits for All Workers Act (S. 1265) of 650,000 lost jobs for high wage workers and 197,000 lost jobs for low wage workers.

The employment effect is substantially overstated for three reasons:

—The analysis assumes that employers have no time to adjust to the mandated coverage. As a result they find a large employment effect for high wage workers. In practice employers are likely to offset this cost by making compensating changes in wages or other fringe benefits for high wage workers, resulting in little or no loss of jobs for high wage workers.

—The estimates assume an average 19.7 percent increase in labor costs to employers of low-wage workers. HealthAmerica limits employer liability to 7 percent

of earnings. The 19.7 percent increase is an over-estimate of the premium impact of the old employer-mandated health insurance plans; in any event it is substantially more than HealthAmerica and other "pay or play" bills currently under consideration would permit.

—The estimates use an outdated estimate of labor demand elasticity by Brown, Gilroy, and Kohen (1983). Newer estimates replicating their work using more recent data by Wellington (1988) cut the impact in half.

Taking these factors into account the estimated job loss would be zero lost jobs for high wage workers and about 30,000 lost jobs for low wage workers.

Short-Term Impact on High Wage Workers

The authors stress that "it is important to note that our analysis is distinctly very short-fun in nature. ... Consequently, our results should be viewed as an upper bound of the effect of a mandate on both uninsured and insured workers." (p. 26) This short-term assumption leads to a gross overestimate of the potential effect of an employer-mandated health insurance plan such as S. 1265. In particular, Monheit and Short assume that employers will not adjust wages and fringe benefits of even high wage workers to offset the added cost of health insurance. This is clearly an extreme assumption. In any legislated change, particularly a change that is phased in gradually, employers could be expected to adjust compensation packages for higher wage workers. Only for workers at the minimum wage where it is not possible to shift the cost back on to workers is there likely to be any marked employment effect. The effect on high wage workers should be negligible, with marginal adjustments toward greater use of labor-saving capital. The estimate of 650,000 lost jobs for high wage workers should instead be close to zero.

Impact on Low Wage Workers

The estimated impact of 197,000 lost jobs for low wage workers is also an overestimate. It assumes that the new health insurance cost to employers averages 19.7 percent of wages. This is an overestimate for S. 1265, and in more recent plans such as the employer "play or pay" plans such as S. 1227, HealthAmerica: Affordable Health Care for All Americans Act, the employer cost is limited to 7 percent of payroll. This is particularly important in the case of part-time workers and low-wage workers, and substantially reduces the labor cost of employer contributions to health insurance coverage.

Monheit and Short also use labor elasticity estimates based on literature on the effect of the minimum wage using data before 1980 (see Brown, Gilroy, and Kohen, 1983). More recent studies replicating this model using data into the 1980's when labor markets have been tighter have found a substantially smaller effect (see Wellington, 1988; Shapiro, 1988). The best current labor demand elasticity effect is -.05, rather than the -.12 used by Monheit and Short.

Correcting for these two effects, a 7 percent increase in payroll cost could be expected to have a .35 percent reduction in employment (i.e. 7*.05). Using the Monheit and Short estimate of 9 million affected workers earning less than $5 per hour, this would imply an estimated reduction in jobs of low wage workers of approximately 30,000.

Health Industry Employment

The Monheit and Short article does not investigate the increased employment in the health industry required to provide health services to the 22 million uninsured members of working families. CBO estimated that the plan would increase health services received by the uninsured or inadequately insured by approximately $15 billion. This will require an increase in jobs in the health industry of approximately 100,000 to 120,000 to provide such expanded health care to the underserved.

References

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COMMENT ON LEWIN/ICF REPORT: ANALYSIS OF HOSPITAL EXPENDITURES AND REVENUES, 1979–1989

Summary

The Lewin/ICF, Inc. analysis of American Hospital Association data on hospital expenditures and revenues is a flawed analysis of the effect of all-payer hospital rate-setting on hospital costs.

It has three major deficiencies:

—It excludes data from the late 1970's and early 1980's when all-payer hospital rate-setting systems were in place and had a major impact on hospital costs.
—It includes data for the late 1980's after all-payer systems were replaced by partial payer systems in New York, Massachusetts, and New Jersey.
—It fails to adjust for multiple determinants of hospital costs in the states it examines. The analysis does not sort out the independent contribution of "competition" or "regulation" on hospital costs.
—The "competitive" states included in the analysis also experienced major changes in public program payment methods for hospital. These changes, particularly the major change in Medi-Cal hospital payment in California, may be as much a factor as HMO enrollment.

Maryland is the only state with an all-payer hospital rate-setting system including Medicare. It has had a systematically better performance than all other regulatory and "competitive" states. Expenditures per patient increased 139 percent in Maryland from 1979–1989, compared with 184 percent in New York, 183 percent in California, 229 percent in Minnesota, and 216 percent nationwide. Yet, the hospital operating margins in Maryland increased 1.3 percentage points over this period.

All-Payer versus Partial-Payer Systems

The Lewin/ICF report picks a curious time period for its analysis. While the report includes tabular information from 1979–1989, the text focuses on trends from 1985 to 1989. However, this was a time period when most of the regulated states included in the study switched from an all-payer system to a partial-payer system. Massachusetts and New York ended their programs in 1985 and New Jersey in 1988—in large part because of hospital industry opposition based on their success in controlling costs. By focusing on the period at the time all-payer controls were removed, the study picks up the acceleration in costs following the switch from all-payer to partial payer systems.

Other studies that have examined the performance of all-payer systems over period when they have been in effect have concluded that all-payer systems are effective in slowing the growth in costs. These studies have analyzed the effect of state all-payer regulation of hospital expenses, after accounting for other factors that may affect costs, such as wage levels, case-mix, and population characteristics. Using data for the 1982–1986 period, Robinson and Luft (1988) found, for example, that growth in hospital costs per admission was reduced in all-payer states, compared with other states. Compared to an adjusted growth rate of 58 percent over the period from 1982 to 1986 in all other states, the growth rate was 47 percent in Massachusetts and Maryland, 52 percent in New York, and 56 percent in New Jersey. Schramm, Renn, and Biles (1986) found that between 1976 and 1984 the rate of increase in hospital expenses per adjusted admission was 87 percent less in rate-setting states than in nonregulated states.

All-payer systems appear to be more effective in controlling costs than partial payer systems. Thorpe and Phelps (1990), for example, found that New York's all-payer regulation reduced inflation in costs substantially, when compared with the partial payer system that preceded it. This would suggest that the Lewin/ICF analysis is merely picking up the acceleration in costs in those states that have changed from an all-payer system to a partial payer system in the late 1980's.

Maryland is the only state to maintain an all-payer hospital system over the 1980's. Maryland experienced an increase of 134 percent in hospital expenditures per admission over the period from 1979 to 1989 compared to 216 percent for the U.S. as a whole. (Author's calculations based on AHA data.) On a per capita basis, Maryland's rate of increase was 139 percent over the period from 1979 to 1989, compared with 216 percent nationally.

Competitive States

The Lewin/ICF analysis purports to compare "competitive" states with regulated states. The five "competitive" states have high rates of enrollment in health maintenance organizations. Yet, another six states with similar levels of HMO enrollment are not included. In fact, California accounts for over 75 percent of hospital states in the five "competitive" states, and the averages basically reflect the California experience. But California is affected not just by 10 enrollment but by major changes in Medicaid payment of hospitals over this period, as well as Medicare prospective payment of hospitals. To what extent the trends in California can be traced to growing HMO enrollment versus changes in public programs, therefore, is unclear.

Hospital Operating Margins

The Lewin/ICF report emphasizes the poor operating margins of hospitals in regulated states. This analysis fails to note that hospital operating margins in the four regulatory states were lower prior to the institution of rate-setting than in other states. This is particularly the case in New York which had negative operating margins in the 1970's, but which has improved under rate-setting to a virtual breakeven position by the end of the 1980's. Operating margins in the four regulated states improved by 1.0 percentage points between 1979 and 1989, compared to 0.2percentage points in the five "competitive" states and 0.4 percentage points nationally.

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The Chairman. Mr. Thorpe, welcome.

Mr. Thorpe. Mr. Chairman, I appreciate the opportunity to appear before the committee to address two of our most pressing public policy issues—the 33 million Americans without health insurance and the sustained growth in health care costs.

S. 1227 takes an important step forward in addressing these issues. You and your colleagues are to be commended for continuing to focus public attention on these critical issues.

My remarks today, however, will focus primarily on the distributional effects of S. 1227 on the private sector.

The provisions of S. 1227 are designed to strengthen our current employment-based system, provide public coverage for the unemployed and many part-time, part-year workers, and provides a national approach to containing our sustained growth in health care costs.

Just quickly, since Professor Davis has already summarized most of the relevant parts of the act, employers would be offered a choice of providing a basic health plan or making a percentage of payroll contribution for public coverage. In most cases, employers would be required to pay 80 percent of the premium, but there are a number of important exceptions.

First, employer contributions would be limited to a specified percent of payroll, which in many cases will be substantially less than 80 percent of a private sector premium.

Second, tax credits are provided to small firms with fewer than 60 employees for each full-time worker earning less than $20,000 in annual earnings.

Again, I highlight these two because it does indeed, as Professor Davis points out, make the financing of this more progressive than it otherwise would be.

It also provides for the establishment of a few Federal Health Expenditure Board. A primary function of the board will be to establish health care expenditure access and quality goals, including the reduction of unnecessary care. I highlight this because I think it is a critical component of this act.

Moving now to the impact, if you look at Table 2, S. 1227 would provide health insurance for all currently uninsured Americans. Approximately 80 percent of them would receive coverage financed through their employer, with the remaining 6.6 million receiving insurance directly through AmeriCare.

To simulate the impact on the employers and workers, I have assumed a 7 percent payroll tax contribution by the employer, although this is not specified under S. 1227. Use of the payroll tax option is in part designed to blunt the economic impact of providing insurance on low-wage firms.

For example, firms with an annual payroll of less than $19,200 are more likely to make the payroll tax contribution rather than providing insurance. Thus a low-wage firm with an annual average payroll of $18,000 would be able to offer its employees comprehensive health insurance at a cost of $105 per month. Other provisions of the bill would reduce this cost even further.

The number of individuals covered by private insurance through their employer after the enactment of S. 1227 would rise from 152 million to 174 million people. This increase includes those previously uninsured as well as others who currently have other forms of insurance, who will now get workplace coverage.

When fully implemented, S. 1227 would facilitate the enrollment of about 47 million Americans into AmeriCare. Enrollment into AmeriCare would allow access to mainstream medical care for these individuals.

Thinking about the short run effects on health care spending, I have estimated that national health care expenditures are likely to rise under the bill by approximately $18 billion, which is about 2.5 percent of what we currently spend. As modest as this national increase is, the distributional effects on employers and households is likely larger. When fully implemented, the new costs facing firms that previously did not provide health benefits for their workers would rise by about $28 billion.

On the other hand, expenditures by employers who currently offer health benefits would fall approximately $15 billion. This figure includes the new costs of covering part-time and part-year employers and financing at least 80 percent of the basic premium. The big savings here is basically that there are about 20 million workers and their dependents who are currently being covered by employers who would now receive coverage under their own employers.

Spending by households would fall by about $23 billion. This includes a reduction of $8 billion in premium payments and an addi-

tional $15 billion reduction in out-of-pocket expenditures. In the short run, health care spending within the private sector will fall by about $10 billion.

The longer-run impacts. The estimates provided above, as I have mentioned, are really just the first-year costs of implementing the program. The real important effects are likely to be in the longer run. For example, employers facing the new cost of providing insurance are likely to attempt to minimize this financial impact. They may attempt to increase prices, adjust other forms of compensation for workers. Moreover, a major concern with benefit coverage like this is its effect on low-wage workers. In particular, an increase in the cost of hiring such workers may lead to layoffs or other adjustments. I'd like to spend just a couple of moments thinking through this issue, since it is oftentimes raised.

I have reviewed nearly 30 major studies by economists, all of them empirical studies, trying to estimate the impact of increases in the minimum wage in the employment of young adults. Among studies of this type, there is an unusual degree of consensus in the literature. In particular, these studies indicate that a 10 percent increase in the minimum wage would at most reduce the young adult employment to population ratio by 2 percent. More recent estimates have a much smaller impact.

In the context of monthly transitions in employment resulting from macroeconomic policy, or reduced employment in industries, the number of jobs that we're talking about being affected in the short run here are quite small. For example, under this bill, the costs of hiring a minimum wage worker would increase by about 7 percent. And if we use these numbers that I have just stated about the effect on the employment to population ratio, we would expect at most an initial reduction in employment of about 50,000 workers.

Thinking about the long run costs, too often many of us focus on the initial costs of this bill, when the real key and important impacts will occur over time. For instance, by doing nothing at current policy, by the year 2000 we'll spend nearly $2 trillion, nearly 20 percent of GNP. Even with a relatively modest reduction in cost growth similar to the rate of increase observed in many rate-setting States, our Nation would spend under 15 percent of GNP on health. This represents a potential savings of $150 billion to all American firms and over $170 billion savings to individuals.

I think it is clear, therefore, that the important economic impact of this bill on the economy is the ability of the Expenditure Review Board to moderate the rate of increase in health care spending.

The CHAIRMAN. You are talking about per year, am I right?

Mr. THORPE. Per year, yes.

The CHAIRMAN. Give those figures again per year, please.

Mr. THORPE. One hundred fifty billion for firms and $170 billion to individuals. Thank you. That concludes my remarks.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Thorpe (with attachments) follows:]

Prepared Statement of Mr. Thorpe

Mr. Chairman, I appreciate the opportunity to appear before this committee to address two of our most pressing public policy problems; the 33 million Americans without health insurance and the sustained growth in health care costs. S. 1227 takes an important step forward in addressing these issues. You and your colleagues are to be commended for continuing to focus public attention on these critical issues.

My remarks will focus primarily on the distributional effects of S. 1227 on the private sector.

Extent of the Problem

On a typical day, over 33.4 million Americans are uninsured. Over 60 percent of the uninsured live in families with annual incomes less than 200 percent of poverty. The uninsured have a strong attachment to the labor force, nearly 75 percent of the uninsured work at some time during the year (see Table 1).

Families are particularly at risk; for instance over 9 million uninsured live in single parent families with another 16 million living in a two-parent family. The relationship between the lack of insurance and health status are well known. Each year, the uninsured receive fewer services, and in many cases, this lack of access compromises their health.

The Response

The provisions of S. 1227, the HealthAmerica Act, are designed to strengthen our current employment-based system, provide public coverage for the unemployed and many part-time, part-year workers, and provides a national approach to containing our sustained growth in health care costs. It would work as follows:

—Each employer would be offered a choice of providing a basic health plan outlined under S. 1227, or make a percent of payroll contribution for public coverage. If the employer provides private coverage, those workers employed more than 17.5 hours per week and their families would be covered. The employer may choose to enroll part-time workers in a public plan (even if private insurance is selected) through a percent of payroll (based on the payroll of part-time workers) contribution.

—The act specifies a basic benefit package consisting of inpatient and outpatient hospital care, physician services, diagnostic tests, prenatal and well-baby care, pap smears, mammograms and inpatient and outpatient mental health services.

—In most cases, employers would be required to pay 80 percent of the premium with employees paying the remainder. There are a number of exceptions:

  —the government would finance the premiums (and other out of pocket expenses for those living in poverty;

  —part-time workers would pay an amount adjusted by the ratio of actual hours worked to 25;

  —employer's contributions would be limited to a specified percent of payroll which, in many cases, will be substantially less than 80 percent of a private sector premium; and

  —tax credits are provided small businesses (except for certain profitable firms)with fewer than 60 employees for each full-time worker earning less than $20,000 in annual earnings.

—The unemployed, some part-time workers, Medicaid beneficiaries and those between jobs would receive coverage through a new public plan, AmeriCare.

—Provide for the establishment of a new federal health expenditure board. A primary function of the board will be the establishment of national health care expenditure, access and quality goals, including the reduction of unnecessary care.

—Through uniform claims billing and other simplifications, the Act will reduce administrative costs of our health care delivery system.

—The Act allows firms with fewer than 100 employees that have not offered insurance to their employees in the year prior to the adoption of S. 1227 to purchase insurance where private payers would use Medicare reimbursement rules to pay providers.

—The provisions of the proposal would be phased-in over a 5 year period.

Impact of S. 1227 on Employers, Employees and Individuals

A. Changes in Source of Health Insurance Coverage

As Table 2 shows, S. 1227 would provide health insurance for all Americans. Approximately 80 percent, some 26.7 million uninsured Americans would receive coverage financed their employer, with the remaining 6.6 million receiving insurance directly through AmeriCare.

By design, S. 1227 provides employers a choice; either offer the basic health insurance package, or contribute a percent of payroll allowing employees to enroll in AmeriCare. To simulate the impact on employers and workers, I have assumed a 7 percent payroll tax (this tax rate is not specified in S. 1227). Use of the payroll tax option is, in part, designed to dramatically blunt the economic impact of providing insurance on low-wage firms. For instance, firms with an annual payroll of less than $19,200 are more likely to make the payroll tax contribution rather than providing insurance (see Figure 1). Thus, a low-wage firm with an annual average payroll of $18,000 would be able to offer her employees comprehensive health insurance at a cost of $105 per month. Other provisions of the S. 1227, noted earlier, would reduce this cost even further.

As noted above, the payroll tax rate ultimately selected is a critical design issue. Among other factors, it will determine the number of employers deciding to purchase AmeriCare or offer private insurance. When fully implemented, all Americans will have health insurance. Under S. 1227, the number of individuals covered by private insurance through their employer will rise from 152 million to 174 million (see Table 3). This increase includes those previously uninsured (plus their spouses and dependents) workers as well as individuals with other forms of insurance (non-group, Medicaid, Medicare) who will now receive workplace coverage. When fully implemented, S. 1227 would facilitate the enrollment of 47 million Americans into AmeriCare. Enrollment in AmeriCare would allow access to mainstream medical care for these individuals. Those sharing in these benefits include existing Medicaid beneficiaries, the unemployed and those outside the labor force, as well as previously uninsured workers whose employers selecting the payroll tax option.

B. Short Run Effects on Health Care Expenditures

Two aspects of S. 1227 will affect the distribution and rate of change in health care spending. In the short run, national health care expenditures are likely to rise by approximately 18 billion or 2.5 percent of national health spending. As modest as the national rise is, the distributional impacts on various employers and households is likely larger. When fully implemented and assuming that employers choose the least cost option of providing coverage (that is either the payroll tax, or offering insurance), new costs facing firms that previously did not provide health benefits for their workers will rise by $28 billion (see Table 5). On the other hand, expenditures by employers who currently offer health benefits will fall approximately $15 billion. This figure includes the new costs of covering part-time and part-year employers, and financing at least 80 percent of the basic premium.

The most substantial savings accrue to those employers who currently cover workers on their health plans who will now receive coverage under their own-employer's health plan. The number of such individuals is substantial as employers currently offering health benefits are financing care for nearly 20 million workers (and dependents of a "secondary" worker) who themselves work full-time. Including these savings, the net initial reduction in spending by such employers would total $15 billion.

In addition to the savings noted above, employers and employees would also benefit through reductions in uncompensated care, through increases in Medicaid reimbursement rates, and by aligning private sector and Medicare rates of payment.

Spending by households would fall by an estimated $23 billion. This includes a reduction of $8 billion in premium payments (which is the net of increased premiums facing higher income workers and reductions in premiums among those previously purchasing non-group coverage). In addition, out-of-pocket expenditures would fall by an estimated $15 billion. In the short run, health care spending> within the private sector will fall by $10 billion.

Longer Run Impacts

The estimates provided above represent the initial aggregate and distributional costs traced to the enactment of S. 1227. Thus, the amount "paid" by employers and households in the longer run are likely to differ from those illustrated in Table 5. Employers facing the new costs of providing insurance are likely to attempt to minimize its financial impact. For instance, employers may attempt to increase prices, or adjust other forms of compensation for workers. Moreover, a major concern with mandated coverage is its effect on low-wage workers. In particular, an increase in

the cost of hiring such workers may lead to layoffs, or other adjustments. As the concern over the employment effects of proposals like S. 1227 are common, I would like to spend a few moments to review its likely impacts on low-wage workers.

Nearly thirty major studies have attempted to estimate the impact of increases in the minimum wage on the employment of young adults.[1] Among empirical studies of economic behavior, an unusual degree of consensus around this issue exists. In particular, these studies indicate that a 10 percent increase in the minimum wage would, at most, reduce the young adult employment-to-population ratio by 2 percent. The most recent studies, examining this relationship through 1986 (Wellington study) indicates, at most, a 0.6 percentage point reduction in the employment to population ratio with a 10 percent rise in the minimum wage. As most employers with minimum wage, or part-time workers are likely to enroll such workers in AmeriCare, one would expect approximately a 30 cent per hour rise in the effective wage paid minimum wage workers. This is approximately a 7 percent increase. Given current employment to population ratios of those working at or near the minimum wage, as clearly an upper estimate, one may expect a reduction in employment of 50,000. It should be pointed out, however, that previous studies note that most of these workers subsequently find new employment, or in many cases many leave the labor market seeking additional training.[2]

In the context of monthly transitions in employment resulting from macroeconomic policy, or reduced employment in industries—in particular manufacturing—facing lower demand, even the upper estimate changes in employment are trivially small during the height of our economic expansion, over 500,000 jobs per month were created. More recently, over 4.3 million workers (having longer than a 3 year tenure) lost their jobs between 1985 and 1990 (see Figure 2). Much of this is traced to the recession and industry-specific changes in product demand. More problematic was the fact that 74 percent of these workers had health insurance. Many of these workers ultimately were re-employed, but often not in firms that offered health insurance benefits. Under S. 1227, all such workers would now receive health insurance coverage.

B. Long Run Impact on Costs

Perhaps the most important economic impact of S. 1227 on both the private and public sector is the establishment of the Health Expenditure Board and allowing certain small firms to use Medicare rules of payment to providers. Both will likely result in substantial reductions in the growth in health care costs. Even more impressive reductions would result should decisions made the board become binding rather than "voluntary". The Medicare program, for instance, has been substantially more effective in controlling costs than most of the private sector, especially small purchasers. Though the initial enactment of S. 1227 is likely to increase spending by some firms, all employers and individuals will benefit if the rate of national cost growth is moderated. For instance, by the year 2000 (at current trends) we will spend nearly $2 trillion, some 19.6 percent of GNP, on health care. Even with a relatively modest reduction in cost growth, similar to the rate of increase observed in many rate-setting states, our nation would spend 14.9 percent of GNP on health. This represents a potential "savings" of $150 billion to all American firms and over a $170 billion savings to individuals. I think it is clear, therefore, that the important economic impact of S. 1227 on the economy is the ability of the expenditure review board to moderate the rate of growth in health care spending. By setting expenditure goals, the board represents a critical first step in allowing our country to moderate the rate of increase in cost, and encourage the diffusion of technologies which examine both benefits and costs.

In sum, I believe the provisions of S. 1227 address in impressive fashion many of the potential shortcomings often attached to workplace-based strategies to cover the uninsured. Portability of coverage is guaranteed by the establishment of AmeriCare. Part-time and seasonal workers would also receive coverage. Through the use of a payroll tax, a slow phase-in, and tax credits, the economic impact on low-wage firm is minimized. Importantly, the establishment of the health expenditure review board provides the basis to ensure that the rate of growth in health care costs re-

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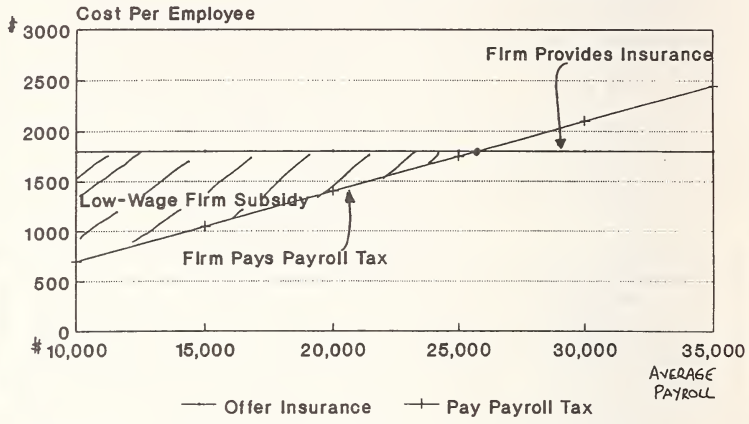
[1] These studies are summarized in Charles Brown, "Minimum Wage Laws Are They Overrated?" *Journal of Economic Perspectives* 2 (3) 1988:133–46. For a recent examination of this relationship, see Alison J. Wellington, "Effects of the Minimum Wage on the Employment Status of Youths: An Update: *Journal of Human Resources* 26 (1) 1990: 27–45.

[2] See, for example, the discussion in Peter Mattila, "The Impact of Minimum Wages on Teenage Schooling and on the Part/Time Full/Time Employment of Youths" in S. Rottenberg (ed) *The Economics of Legal Minimum Wages,* Washington, DC, American Enterprise Institute, 1981:11–87.

ceives the national attention it deserves. You and your colleagues are to be congratulated for taking this innovative and important step in addressing a pressing national problem.

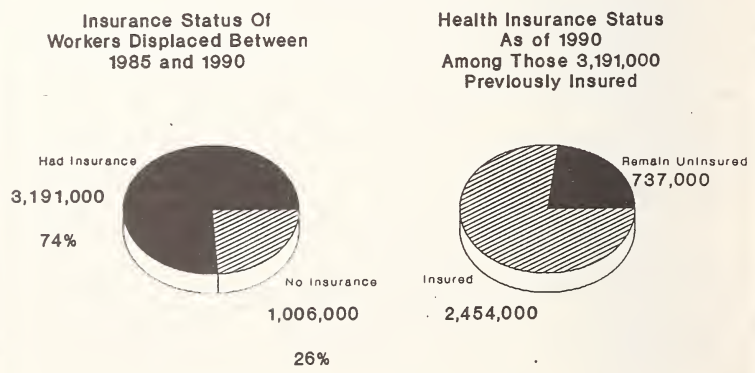
Once again, Mr. Chairman, I thank you for the opportunity to appear before the committee today, and would be pleased to address any questions you or your colleagues may have.

FIGURE 1 **Cost Per Employee Under S. 1227: Payroll Tax Vs. Offering Insurance**



Assumes 7% tax rate

Figure 2 **Displaced Workers By Previous and Current Insurance Status**



SOURCE: Monthly Labor Review, May 1991

Table 1. **Characteristics of the Uninsured, 1989**
(millions)

Total	33.4
Annual Family Income (% Poverty)	
0-99	9.6
100-199	10.6
200-299	5.9
300-499	4.5
500+	2.7
Family Structure	
Individual	6.0
Childless Couple	2.6
Single-Parent	9.1
Two Parent	15.7

Source: Tabulations from Current Population Survey, March 1990

Table 2. **Changes in Health Care Coverage, Before and After Enactment of S. 1227**
(millions of persons)

Family Income (% Poverty)	Previously Uninsured	Receive Workplace-Financed Coverage[1]	Covered Under AmeriCare
0-99	9.6	6.3	3.3
100-199	10.6	8.8	1.8
200-299	5.9	5.1	0.8
300-499	4.5	4.0	0.5
500+	2.7	2.5	0.2
Total	33.4	26.7	6.6

[1]Workers may receive coverage either through AmeriCare or through private insurance. Totals reveal number receiving some employer support, either directly through a premium contribution or through a payroll contribution to AmeriCare.

Table 3. **Insurance Status Before and After Enactment of S. 1227**
(millions of persons)

	Before	After	Change
Employer-Based (Private)	152	174	22
AmeriCare	0	47	47
Medicaid[1]	23	0	(23)
Medicare	30	28	(2)
Other Private[2]	16	5	(11)
Uninsured	33	0	(33)
Total	254	254	0

SOURCE: Author's tabulations from Current Population Survey, March 1990.

[1]Includes some individuals covered by other forms of insurance at some point during the year.

[2]Includes those purchasing non-group plans, CHAMPUS and VA coverage.

Table 4. **Premium Cost of Basic Health Plan Specified Under S. 1227** *

Firm Size	Single	Family
1-24	$1390	$3315
25-99	$1280	$3105
100 +	$1240	$3075
Average	$1285	$3160
Average Per Worker	$1680	

* Employer and Employee Share

Table 5. **Health Care Expenditures Before and After Enactment of S.1227** (billions of 1991 dollars)[1]

	Before	After	Change
Employer-Paid Premiums			
--Firms That Currently Do Not Offer Insurance	$0	$28	$28
--Firms That Currently Offer Insurance	$168	$153	($15)
Households			
--Private Premiums	$118	$110	($8)
--Out of Pocket	$162	$147	($15)
Private Total	$448	$438	($10)
National Total	$756	$774	$18[2]

SOURCE: Author's calculations based on Commerce Department data, data from the Office of the Actuary, HCFA and the Pepper Commission report.

[1] Represents initial change in expenditures. May not reflect longer term incidence.

[2] Does not include an estimated $9 billion in savings traced to the cost containment features and administrative savings during the initial year of S. 1227.

Table 6. **Health Care Costs With and Without Cost Containment**
(billions of current dollars)

	YEAR	
Employers	1991	2000
Current Policy[1]	$224	$574
With 2% Point Reduction in Growth	$224	$434
Households		
Current Policy	$279	$713
With 2% Point Reduction in Growth	$279	$540
Total		
Current Policy		
Dollars	$756	$1,931
% GNP	13.4	19.6
With 2% Point Reduction in Growth		
Dollars	$756	$1,465
% GNP	13.4	14.9

SOURCE: Author's tabulations based on data from the Commerce Deparment, the OASDI Trustees report (Alternative II assumptions for GNP growth) and Office of the Actuary, HCFA.

[1]Includes contributions to Medicare's HI trust fund, plus public employers.

Responses to Senator Kennedy's Questions

Kenneth E. Thorpe
University of North Carolina at Chapel Hill

1. A major concern with S. 1227 is its potential impact on low-wage workers. Specifically, an initial increase in an employer's compensation package may lead to layoffs, or other adjustments by the employer. Of special concern are those workers at or near the minimum wage. As employers cannot, by law, reduce their cash wages to offset increased costs of providing insurance, many fear that these workers could be displaced. A number of estimates of the employment effects accompanying proposals like S. 1227 have been completed. The two studies in question, CONSAD Research Corporation's and the one by Monheit and Short have serious methodological shortcomings, and therefore arrive at erroneous conclusions.

With respect to the CONSAD study, they ignore over twenty years of empirical research conducted by a broad array of economists. These studies, which have examined the employment impacts associated with an increase in the minimum wage, have reached an unusual degree of consensus. The most recent study, completed by Alison Wellington and published in a highly respected economics journal indicates that, <u>at most</u>, a 10 percent increase in compensation is associated with a 0.6 percentage point reduction in the employment to population ratio. Given current levels, this would reduce the current employment to population ratio from .52 to .514, a trivial decline (implying a job loss of approximately 50,000 to 80,000 jobs). CONSAD's findings of 5.8 million jobs at risk are based on assumptions which have no empirical basis. Instead of relying on the years of focused research on this issue, CONSAD used their own assumptions concerning the impact of increased compensation on employment. These assumptions are magnitudes higher than those relying on any empirical evidence. In short, the assumptions used by CONSAD appear from thin air, are not referenced, they are not supported by any published economic evaluation and therefore should not be taken seriously as an estimate of the impact on labor supply.

The Monheit and Short study arrive at a substantially lower estimate that CONSADs. Their analysis indicates that proposals like S. 1227 would jeopardize the jobs of, at most, 847,000 workers (about 15 percent of the numbers indicated by the CONSAD study). The approach used by Monheit and Short have some merits, although unfortunately they misuse the empirical studies cited previously to arrive at their estimates. They note that proposals like S. 1227 could increase the hourly costs of employing low-wage workers by nearly 20 percent (this is not based on the specifics of S. 1227 which result in substantially smaller increases, on the order of 7 percent). They subsequently apply the research results summarized by Professor Brown in his often cited summary of the research in this area and presume that 2.5 percent of affected workers could lose their jobs. While based on the research literature, this estimate has two shortcomings; first, it does not correctly apply the job loss estimates to the data at hand, and second, their estimate does not apply to the type of mandate developed under S.

1227. A correct use of the literature would have indicated that a 20 percent rise in the minimum wage is associated with a 2.5 percent reduction in the employment to population ratio, not employment. Properly used, this results in a lower estimate. Second, even given their methodology as it relates to S. 1227, a 7 percent rise in the costs of compensating low-wage workers (as allowed when workers join AmeriCare) would be associated with a job loss of 70,000 to 300,000 workers.

2. Moving to a fully-tax financed national health program would require an increase in public sector spending of (at least) $500 billion (and a commensurate decrease of $500 billion in private sector spending). In 1992, this new federal responsibility would have increased the dollar volume of taxes raised by the federal government by some 45 percent. Though the $500 billion is, in many respects, not "new" money spent on health care, it would involve a substantial change in how health is financed. Clearly, a number of revenue options are available. To put the magnitude of the tax increase in perspective, the $500 billion would involve a doubling of individual income tax receipts from current levels. This approach, while technically progressive, seems a particularly unattractive approach. A more eclectic approach would include the following; it is an open question (and as is outlined below , quite questionable) whether the pattern of tax increases is more progressive than our current financing arrangement.

Tax Source	Revenues Raised (Billions of 1991 Dollars)	Degree of Progressivity
10% Value Added Tax	$240	Low
3% Payroll Tax, No Income Limit	$110	Neutral
Increased Motor Fuel Tax (40 cents)	$ 35	Low
Increase Marginal Income Tax Rates To 35%, With 5 Percent Surcharge To Everyone's Liability	$40	High
Treat Employer Paid Health Insurance Premiums As Taxable Income	$35	High/Moderate
Total	$460	Moderate

Unless the entire tax burden were raised through the income tax system, the pattern of taxes capable of generating a 45 percent increase in the federal budget raises serious questions about its progressivity (let alone the disruptions and new distortions introduced by such a massive redirection of income) relative to our current system. Given the large scale redistribution of income inherent in such an approach, it seems unwise to support tax-supported health insurance proposals in the hope that it will redress income disparities in the United States.

The CHAIRMAN. Mr. Butler.

Mr. BUTLER. Mr. Chairman, thank you for the opportunity to testify today on the probable impacts of S. 1227.

While I have serious misgivings regarding the particular bill, I want to commend you and other members of this committee as well as Senator Mitchell for taking the lead in addressing the problems of health care in America.

I also want to emphasize that, like you, I agree that our goal should be to create a system that assures affordable access to health care for all Americans while keeping the costs to society within bounds. The problem, of course, is how to achieve that.

In testimony before the House Budget Committee recently, Senator Mitchell pointed to the fact that today's health care system is an accident of history, not the result of a grand design. He added that by separating the receipt of health care from the payment for care, that system has resulted in the problem of overutilization by many Americans, plus rapid inflation in the system.

I would add that the current tax treatment of health care compounds this problem in two ways. It encourages over-insurance and inflation by creating the illusion among consumers of a free good; and it is grossly inequitable, giving generous tax breaks to many Americans who do not need them while denying tax help to millions of uninsured Americans struggling to buy insurance protection.

This situation of perverse consumer incentives combined with inequitable government help can be remedied, in my opinion, in one of only two ways. One way, as we have proposed at The Heritage Foundation, is to build a true consumer-based universal health system by reforming the tax treatment and other aspects of today's system to create positive incentives and tax assistance to those in need.

The other approach favored on this committee, I believe, by Senator Wellstone would be to deal with perverse consumer incentives by establishing the government as the funder and allocater of health resources. I have lived under such a system in Britain; Canada represents another example. And while I do not support such a system, it does have an internal logic and consistency.

The fundamental problem with a third approach, represented by S. 1227, and indeed, all "pay or play" approaches is that in trying to build on today's system and creating a hybrid system, it includes the worst features of the two polar alternatives I have outlined, but few of their virtues.

Moreover, I believe the system created by S. 1227 would be politically unstable and would quickly evolve into either a pure public system or a pure consumer-led system.

I would advise the committee to save time by choosing now between those alternatives.

Let me point to some of the specific features of the "play or pay" model that lead me to this conclusion. First, as the CBO pointed out in its July analysis of health reform options, a mandate on employers will induce many firms to lay off workers and reduce hiring as labor costs rise. The tax or "pay" feature of the Mitchell bill only distorts this incentive; it does not eliminate it. Businesses whose health benefit costs exceed the tax rate will tend to "dump"

their employees into the public program, and that of course would tend to lead to a deficit in that program as the risks associated with those employees is higher than the tax rate.

If the tax rate is raised, the number dumped will be smaller, but they will tend to be high-cost families. And I would point out that as you raise the tax, of course, that places greater economic costs on particularly smaller and medium-sized firms and will have hiring effects as a result of that.

Second, there will be a powerful incentive for employers who "play" to discriminate against job applicants who pose potentially high medical costs for the firm. The CBO also makes this point, by the way. That happens today, of course, but it would intensify under the bill. Congress and the courts will have to apply very strong and complex anti-discrimination measures if this is to be avoided—perhaps even stronger than those in the bill. And I would point out that those in the bill are themselves very strong and could lead to endless litigation particularly by those who are not hired by firms, and very draconian penalties associated with this.

Faced with this prospect, I doubt if it will be long before firms try to avoid that litigation by pressing Congress to end the employer-based system and enact a full national health system.

Third, I have little doubt that the cost control aspects of the bill will be ineffective. As long as the consumer faces perverse incentives and yet can trigger health care spending through his or her choices, neither government nor private firms will be able to control costs. Medicare, after all, has even more stringent price controls than those envisioned in S. 1227 and yet has not held down costs.

Similarly, business efforts to control costs have been disappointing. Thus, I believe the controls in the bill will have to become more widespread and tougher simply to stop consumers and providers avoiding cost constraints. The ultimate result, I believe, will be virtually indistinguishable from a pure government-run system.

Fourth, the political process will tend to cause the basic benefits package in the legislation to expand, making it harder for firms and the government to control total costs. Today firms can at least negotiate with employees over their benefits and can sometimes insist on reasonable cost savings. But with a Federal mandate, the tendency of organized labor will be to come to Congress to obtain more generous benefits if unions cannot win them at the bargaining table. Providers, too, will come to Washington to press for more services to be added to the package, just as they have done at the State level through insurance mandates.

Thus I believe in the long run that American business and the Federal Government will find the system created by S. 1227 to be increasingly costly and unsatisfactory. In particular companies faced with a mandate that makes cost control more difficult and with steadily more stringent anti-discrimination and anti-dumping rules will clamor to be taken out of the equation. Similarly, government will face a continuous and uphill battle to block what amounts to adverse selection against the public program.

I have little doubt that the final outcome of dissatisfaction with the results of S. 1227 would be that Congress would soon have to revisit fundamental health care reform. Then it will be forced to

choose between two internally consistent systems that recognize the power of consumer choice—one that uses it to advantage and one that eliminates it.

I would simply advise Congress to make that choice now—not after trying a third approach which in my opinion will not work.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Butler follows:]

Prepared Statement of Mr. Butler

Mr. Chairman, my name is Stuart Butler. I am Director of Domestic and Economic Policy Studies at The Heritage Foundation. Thank you for inviting me to testify today on the likely impact of S. 1227, proposed legislation to provide affordable health care to all Americans. I emphasize that my remarks represent my personal views, and those of my colleague Edmund Haislmaier, who assisted in preparing this testimony. They should not be construed as representing any official position of the Heritage Foundation.

I would like to begin my remarks by quoting from statements made by Senator George Mitchell, the Senate Majority Leader and principal sponsor of S. 1227, when he recently testified before the House Budget Committee concerning this legislation.

During his testimony, Senator Mitchell made the following astute observations:

—Many years ago, not by any grand plan or design to meet what was, in fact, an unmet need in our society, we began a process which has resulted in the separation of the payment for health care from the receipt of health care services. That has met, to some degree, what was an unmet need; but it has, at the same time, created overutilization and a problem of attitude with respect to the quantity of health care services.

—Consider this fact: In ours and every developed society, there has grown, in recent years, a very large industry based upon the simple premise that a person who can defer the payment for a good or service will purchase more of those goods or services. I confidently predict that almost everyone in this room has one or more credit cards in their pocket. It is a large and very successful industry, which operates on that simple premise: If we can defer payment, we will buy more of things. In fact, we do.

—Imagine then, the effect on attitude if another person believes that they do not have to pay at all. If their attitude is, I am not paying anything for this, we readily, of course, are prepared to purchase more.

—To some extent—and it ought not to be exaggerated—but to some extent, that is a factor in overutilization and the volume of services provided today.

—. . . I think we have to begin to change attitudes and convince every American that they are paying because, in fact, they are.

Senator Mitchell has, in my opinion, clearly identified the driving force behind many of the current problems with America's health care system, namely that the current system largely divorces the payment for health care from the receipt of health care services.

One group—beneficiaries—are concerned primarily with the receipt of health care services. But because they are insulated from the true costs of those services, they have little interest in those costs. Another group, businesses and governments, are concerned primarily with paying for health care. Since businesses and governments are merely legal entities, they do not use health care services, and thus have little natural interest in the quantity or quality of those services delivered to patients.

At the same time, under this system, providers naturally offer more services and seek to charge more for them. Normally, in the rest of the economy, this tendency would be constrained by consumers demanding the highest benefits at the lowest cost. But health care providers function in a very different environment from that faced by providers of goods or services in other areas of the economy. Providers elsewhere must constantly balance the prices they charge with the quantity and quality of the goods or services they offer—if they are to survive. That does not happen sufficiently in health care because consumers generally have little incentive to challenge cost.

What is missing, then, from the current health care system is any effective mechanism for balancing costs with quantity and quality. There is simply no mechanism for seeking or obtaining good value—that is, the best quantity and quality at the best price—for either Americans as individuals or society as a whole.

This fundamental defect in the existing system can only be remedied in one of two ways. Either the system must be changed to give those who benefit from health services direct control over the funds used to pay for those services—a consumer-led model—or it must be changed in the opposite direction by eliminating the ability of consumers to demand services without regard to cost. This is accomplished by giving control over the supply of health care completely to government officials who can safely ignore the inefficient demands of consumers. These are the only two ways to effectively solve current problems in the health care system. A hybrid system, epitomized by "play or pay" proposals such as Senator Mitchell's bill, is not in fact a compromise between these alternatives. In practice it would combine the worst features of each approach and would be economically damaging as well as politically unstable.

The first approach I mentioned—the consumer model—necessitates sweeping reforms based on consumer choice and market principles which would give individual Americans and their families direct control over the funds used to buy their own medical care and health insurance. Such reforms would be accompanied by some structure of direct subsidies, through the tax code or public programs, to provide lower-income or chronically sick individuals with the extra funds they require to purchase needed medical care and health insurance equal to that of the rest of the population. This is the approach which I, among others, advocate.

The second approach also necessitates sweeping changes to eliminate the problem that consumers, facing perverse incentives, are not encouraged to use health resources efficiently, or even effectively. These changes would grant government complete and direct control over the system, including the key economic levers of price, quantity and quality, through a national health insurance program. Such a program could be structured along the lines of either a public service model, such as the British system, or along the lines of a closely regulated public utility model, such as the Canadian system. Various individuals, including some members of Congress, advocate this type of approach. I do not agree with this approach, but it is the only real alternative to a consumer-based system.

I do not see any third choice. Specifically, I do not see how pursuing any course of reform, other than the two choices I have described, will result in a system that is politically or economically workable. Trying to pursue a third way that is based on neither of these fundamental options, or an attempted combination of the two, will only create a more unstable and ineffective system—leading to eventual reform in one of the two directions I have outlined. The effect of such a measure will be only to delay the inevitable day of final decision.

Unfortunately, Senator Mitchell and others, including the Chairman of this committee, have chosen to pursue that unworkable third approach in S. 1227.

The basic elements of S. 1227 are:

(1) The establishment of a federally-defined basic minimum package of health insurance benefits for all Americans.
(2) A requirement that employers either purchase health insurance coverage for their workers and dependents from private insurance companies, which meets or exceeds the federally-defined minimum, or pay a new payroll tax to fund government-provided health insurance for their workers and dependents.
(3) The replacement of Medicaid with a new public assistance program providing health care coverage to all Americans lacking private, employer- provided insurance.
(4) A new set of regulations and restrictions on how private health insurers write policies and conduct business.
(5) The creation of a new mechanism of government-sponsored negotiations and government-imposed regulations designed to control the quantity, quality and cost of health care services throughout the entire system.

While there are differences in the details, S. 1227 is no different in basic structure from other proposals based on the concept of health care reform commonly known as a the "play or pay" approach.

Rather than presenting a detailed analysis of S. 1227, I will, in the rest of my testimony, comment on what I see as the major flaws of this legislation and of all similar play or pay proposals. I do this because over the long haul the details are of marginal significance. The eventual outcome will be driven by pressures emanating from the fundamental dynamics of play or pay.

The premise of the play or pay approach is that, because the majority (over 80 percent) of American workers and their dependents currently receive health insurance coverage through the workplace, those who currently lack health insurance should also receive coverage in the same manner. It is assumed that the absence of

universal employer sponsored coverage is due to negligence on the part of some employers. The conclusion, based on this reasoning, is that employers 'not now providing these benefits should be forced either to provide coverage by private means, (i.e., "play"), or fund the cost of government administered coverage, (i.e., "pay"), for uninsured workers and their dependents.

The premise that the absence of universal employer sponsored coverage is due to simple negligence or a desire to "free-load" on the part of some employers is largely wrong. Surveys show that workers consider the existence or absence of employer provided health insurance to be a major consideration when choosing a job, and that employers feel competitive pressure to offer health insurance as a means of attracting or retaining workers.

The real reason most uninsured Americans lack health care coverage is simply that they and/or their employers are unable to pay the cost of a reasonable health benefits package. The reason for this is that the current policy of providing incentives for employers to provide insurance is inequitable and contains highly perverse incentives that push up costs.

For employees, the only way to obtain significant assistance towards health care costs, short of going on welfare, is through the exclusion for company-provided plans. This provides generous tax relief to employees on high tax brackets and least help to workers on the lowest bracket. If the employee works for a small firm without a plan, he or she usually must pay for insurance or care in after-tax dollars. Thus the design of assistance is exactly the reverse of the principle of providing most help to those who need it most. In addition, many workers see employer-provided coverage as "free" to them and have little incentive to economize, especially if it is first-dollar coverage. And insurance at the place of work means that the coverage is not portable—thus many employees with medical problems either are unable to move to a better job, or face a financial catastrophe if they are without work even temporarily.

For businesses, the cost of covering employees includes not only the cost of insurance premiums but also the substantial, hidden administrative costs imposed by government regulation of employee benefits plans. These administrative costs explain why some businesses do not offer insurance to short term employees, even if they are otherwise highly compensated. It is also a major deterrent to small businesses (where most uninsured workers are employed) offering insurance. Furthermore, group insurance through the place of work means higher overhead costs for small businesses.

The effect of a play or pay scheme, such as that in S. 1227, thus would be to force employers or workers who cannot afford health insurance to buy it anyway (either privately or through the government), with money they must take from somewhere else.

The play or pay approach is also premised on the fallacious assumption that there is no difference between an incentive and a mandate. A government subsidy, such as the current tax exclusion for employer provided insurance, encourages people (to the extent they can afford them) to obtain the goods or services in question. The magnitude of the subsidy will determine how many people are induced to purchase and to what degree. In contrast, people seek to evade mandates, or limit their effects. Given that the existing incentive of a tax subsidy for employer-provided insurance results in coverage for over 80 percent of the population, the better way to provide coverage to the remaining population is by reforming existing tax subsidies. In that way, existing tax assistance could be targeted more to those who really need it—especially those who are not employed in large firms and those who move often between jobs.

A play or pay system, on the other hand, will have significant economic and political implications of a very different kind. Among them:

(1) *There will be incentives to avoid hiring employees with potentially high medical costs and to "dump" such workers on the public plan*

The Mitchell bill will create a perverse incentive for businesses currently providing health insurance to drop coverage for some or all of their workers. The employment effect of an employer mandate was referred to recently by the Congressional Budget Office, in its July 1991 report, *Selected Options for Expanding Health Insurance Coverage.* According to the CBO:

> Some employers might reduce their work force by laying off workers or by reducing the hours of those who remained employed. In addition to reducing the number of full-time workers, firms would have an additional incentive to restrict some workers to part-time work below the threshold in order to avoid the mandate altogether. This incentive would be particularly strong if a large pro-

portion of a firm's workers were near the threshold set by the mandate [page 39].

Moreover, regardless of the nature of the required basic plan, or the size of the tax imposed as an alternative to providing insurance, play or pay will set in motion an unintended cycle of adverse selection and employment discrimination. All businesses whose health benefits are comparable to the government plan, but whose costs exceed the payroll tax, will have an incentive to pay the tax and dump their employees onto the government plan.

Raising or lowering the amount or percentage rate of the tax will only compound problems in one direction or another. The lower the tax, the greater the number of workers who will be dumped on to the public plan. The higher the tax, the fewer workers will be dumped, but those will disproportionately be the workers who are most expensive to insure.

In fact, it will never be in the interest of employers to pay the tax for workers who cost less to insure than the amount of the tax. At every tax rate the cost of insuring those workers dumped on the government plan will exceed the revenues raised by the tax to fund their insurance, and the new government program will always operate at a deficit if it is to be paid for out of payroll tax revenues.

Regardless of whether employers comply with a play or pay system by buying insurance privately or by paying the payroll tax to cover their workers under the new public program, the effect will be the same. Mandating extra employer-provided benefits, like increasing by law any other cost of hiring employees, depresses cash wages and/or reduces employment. Furthermore, the cost of those actions is borne not by employers but by the workers themselves, and the hardest hit would be the lowest wage workers—the same ones who are most likely to lack health insurance.

While economists debate the extent of such job losses, there is no question that they will occur under a play or pay system. Of course, the higher the payroll tax, the greater the job losses will be. Before enacting such a system, I suggest that Congress stop to consider the possibility that low-income families might consider a job to be more valuable than a government health plan.

(2) *Government will have to take ever-tougher action to combat discrimination in hiring, likely resulting in firms pressing Congress to adopt a more radical reform of the health system*

A play or pay system would not only give employers a strong, perverse incentive to dump costly workers and their families on to the government program, it would also give them a powerful incentive to avoid hiring workers whose families will be costly to insure. Quoting again from the CBO analysis:

> Employers forced to provide health insurance for the first time would have an incentive to discriminate against workers with high insurance costs. For example, an employer would prefer to hire a married woman who is likely to be covered by her husband's more generous policy instead of hiring a single parent with children. [page 39]

While S. 1227 attempts to prevent such behavior through its anti-discrimination provisions, in reality such natural and logical discrimination would be very difficult to stop. In fact, I foresee Congress and the courts steadily having to impose greater penalties or invoke the full force of civil rights legislation if they are to stamp out such financially-induced discrimination. I suspect the ultimate reaction of business will be to press for Congress to enable them to avoid a painful dilemma by enacting a comprehensive national health insurance program paid for out of taxation. Or businesses will demand that consumers, not businesses, be required to obtain medical plans and be granted tax relief to afford such plans. In other words, I believe the play or pay model is politically unstable, and likely will evolve into one of the polar alternatives I discussed at the beginning of my testimony.

(3) *Play or pay will require steadily tighter and more sweeping price and volume controls, leading to a system indistinguishable from a government-operated national health system*

By legislating an arbitrary minimum benefit package employers must provide, and an equally arbitrary tax they must pay if they fail to provide those benefits, the government would force firms that have kept their health care costs under the tax level to make up the difference or drop their coverage. Thus the system would punish the firms that have done the best job in controlling costs.

Nor do I think that the cost control provisions contained in S. 1227 will prove effective. Without digressing into a lengthy and technical discussion of the likely effects of those provisions, I will simply observe that the present Medicare system has

even more stringent price-setting authority than that proposed in S. 1227 and yet it has not been able to control cost escalation.

Thus I believe once again the health system envisioned in S. 1227 is inherently unstable and will evolve into something else, most probably a system more like the Canadian or British system. As limited price-setting authority is found to be ineffective, the tendency will be for increasingly stronger controls—and for steps to be taken to draw more aspects of the health system under control, in order to avoid adverse selection against the government.

(4) *The "basic" benefits package will expand. raising the taxpayer cost of the public program and blunting current business-led efforts to control costs*

Mandating any minimum benefit package on employers would result in enormous constituency pressure on Congress to add more and more services under the mandated minimum benefit package, and to reduce its cost-sharing requirements on beneficiaries. This pressure would come from consumers desiring more "free" or "lower cost" services.

Medicare offers a good example of this kind of behavior. When the program was created in 1965, the out-patient deductible was set at $50. It has only been increased three times since then to its present level of $100. Yet, had the deductible kept pace just with general inflation it would today be $220. I strongly doubt that the provisions in S. 1227 stipulating annual inflation adjustments in deductibles would last long under pressure from constituents to freeze or lower them.

Pressure would also come from providers initially excluded from the system. Having the government require people to buy your services is a great way to guarantee your income. There can be little doubt that Congress would also bow to this pressure. State legislators have already done so, enacting over 800 laws in the past fifteen years requiring insurers to cover specific providers or services—even when consumers expressed little or no interest in the benefits. The political and economic problem of state insurance mandates, which artificially increase the cost of insurance and medical care, would simply be transferred to the federal level.

These pressures will combine to undermine the efforts of businesses today to hold down costs by negotiating with organized labor and by redesigning health packages. Organized labor, perhaps understandably, will have the incentive to achieve increases in benefits through the political process rather than at the bargaining table. And provider groups similarly will turn to the political process when they feel excessively squeezed by : employers trying to curb costs.

Some large businesses, with well paid workers and generous benefit plans, on the other hand view play or pay as a way to lower their own health care costs. Those businesses argue that their health insurance costs are unnecessarily high because providers increase charges to their insured workers to cover the cost of providing free or low-priced care to the uninsured. They believe a play or pay system would shift those costs back to the employers who do not provide insurance.

Eliminating current health care cost shifting in which the cost of treating the uninsured is added to medical bills paid by the insured is not, contrary to the arguments of some large businesses, a valid reason for adopting a play or pay system. If employers themselves paid for health insurance, there might be some justification to this argument. But they do not—employees pay for health insurance. Employee compensation equals cash wages, plus non-cash fringe benefits, plus payroll taxes paid by employers. Employees with tax-free employer sponsored health benefits generally earn much more than workers without such benefits. Thus, despite the inefficiencies of a system in which those with employer-provided health benefits cross-subsidize those without such benefits, in reality it is a far more progressive "solution" than imposing an additional payroll tax on the uninsured, which would cut the cash wages of lower-paid workers.

(5) *Play or pay is regressive*

While the current tax exclusion for employer-provided insurance is regressive, with the benefits accruing to disproportionately to the more affluent, that regressivity is partly offset by the informal system of cross-subsidies which funds uncompensated care for the low-income uninsured, who receive no tax breaks on their medical care. Replacing those cross-subsidies with a new payroll tax on low-income workers, as S. 1227 would do, is even more regressive and is probably the most regressive policy Congress could devise. I do not believe it is the intention of this committee or Congress to fund America's health care system by taxing the poor. Yet, that is precisely what S. 1227 would do.

As I noted earlier in my remarks, I believe that the play or pay approach on which S. 1227 is built is inherently and irredeemably unstable. It is unstable both in economic terms and in political terms.

It will not control health care costs. It will cause many Americans to lose their jobs. It will encourage discrimination against potentially high cost applicants for jobs. It will set in motion a cycle of public and provider demands for more covered services and lower copayments. It will be regressive, penalizing low-income Americans with a new payroll tax. It will depress cash wages. And finally, the payroll tax mechanism will force Congress to chose between the two fundamental options I outlined at the beginning of my testimony.

If the payroll tax is set high, then a largely private system will be preserved, but at a cost of greater unemployment, business failures and reductions in cash wages. If Congress tries to ameliorate those adverse consequences by extending or expanding the tax relief contained in S. 1227 or other offsetting subsidies to businesses and individuals, it will be a day's march closer to the private, consumer-oriented approach I advocate.

If, however, the payroll tax is set low, then an increasing number of Americans will be dumped into the public plan and Congress will be a day's march closer to the national health insurance system advocated by others.

In the final analysis, there is a certain inherent logic to a consumer-oriented, market-based system. There is also an inherent logic to a government-based, national health system which substitutes government allocation of resources and government assessment of value of benefits. However, there is no inherent logic to a play or pay system of employer mandates.

As Senator Mitchell noted, our present system is the product of historical accident and not design. In light of the problems it has generated, Congress should avoid extending this system through a play or pay system. Indeed, there is every reason to replace it with one or the other of the two fundamental systems I have described. I urge this committee and Congress to make that fundamental and necessary choice sooner, rather than later.

The CHAIRMAN. I would note that the members of the committee who are here is a pretty good reflection, I think, of the interest generally in the Senate across the table, with Senators Kassebaum, Durenberger, Jeffords, and my colleagues Senators Wellstone and Simon. We are delighted that they could all be here to hear these excellent presentations.

Let me just ask both Karen and Ken do you believe that a "pay or play" system is inevitably headed for rejection or failure or disaster, and if not, why not?

Ms. DAVIS. No, I do not agree with that. I think there is no evidence that you would get an unstable situation. I think there is reason to believe that certain employers will prefer public plan coverage. After all, a public plan is going to run lower administrative costs; the 7 percent of payroll would be attractive to low-wage firms, so certainly you would expect those to go into public plans.

I disagree with Mr. Butler that "dumping" people into a public plan, any more than covering the elderly and disabled, is in some way "dumping" people into Medicare. It is assuring them of a good program and good coverage.

So I don't see any reason to believe that this is an intermediate step that is inherently unstable. I think it gives every employer the option of deciding for themselves what works best for their firm. If they want to continue their current private coverage they can do so; if they want public coverage, they have got a good option of one with a proven record. Mr. Butler said that Medicare has not succeeded in controlling costs. I think the record is very different. If you look at the case of hospital services, where in 1983 Medicare moved to a new system of paying hospitals, they have held the rate of increase in real hospital spending per beneficiary to less than one percent—0.5 percent—a very good record of cost control under Medicare.

So I think it gives two attractive options to every employer, and it is there to meet the special needs of low-wage workers.

The CHAIRMAN. Mr. Thorpe.

Mr. THORPE. I guess I would tend to agree. The "pay" option here provides an opportunity both for low-wage firms and for small firms to get coverage at a very affordable rate in terms of the premium. And again, the thing I'd probably want to highlight here is that the administrative costs of dealing with small employers under this provision would be dramatically lower.

Trying to organize insurance around a small firm is inherently a very expensive enterprise, and one of the nice features of the option of coming into a plan like AmeriCare is those administrative costs would eventually look something like the administrative costs of running the Medicare program, which by the way is also administered by private health insurance.

The second point I would make is that by tying the contribution to payroll, this does provide some direct parameters on what the Health Expenditure Review Board is going to have to let health care costs grow by—meaning that health care costs can't grow substantially faster the way that we have now than payroll. You could come into a situation where over time, more employers would find the public fund more acceptable.

So I think that the payroll contribution provides a check for the Expenditure Review Board when they are setting up guidelines and budgets that is a very powerful check and is something that is a very important feature of the proposal. So I think tying it to payroll puts some natural limits on the system, and second, the administrative costs of enrolling small firms under a proposal like this are very, very low.

The CHAIRMAN. What about the suggestion that there will be a number of particularly low-wage workers in small firms who would be effectively dumped into a pool, and that we'll just have another Medicaid system, and that there will be a loss of interest in that type of program and a deterioration in terms of quality of those individuals. Do you see that as an inevitability?

Ms. DAVIS. Again, I don't see that at all. We've got a very good record, for example, with the Medicare program. It provides good benefits to over 33 million elderly and disabled Americans. So I think if one wants to make it a good program, particularly with the approach in HealthAmerica of setting Federal standards on benefits, having a national Health Expenditure Board that would be negotiating provider payment rates where one would try to achieve the same kind of rates applicable to the care of all patients, where you would have uniform eligibility. A lot of the problems with the Medicaid program today are the extreme variations from one State to another. A State like Alabama sets eligibility at 15 percent of the Federal poverty level. This plan would bring that up to 100 percent of the poverty level, so a poor individual in any State would be assured of having coverage.

You've got a uniform benefit package. You have to cover preventive services such as mammography and Pap smears. You can't set limits on hospital and physician services the way some Medicaid programs do.

So I think you can certainly build it by the way you set it up to make sure it is a good program that would cover not just low-income people but also working people, early retirees, the disabled who haven't yet qualified for Medicare, spouses of Medicare beneficiaries I would see being in this plan. So I think it would have a lot of appeal to a lot of people.

The CHAIRMAN. Mr. Thorpe.

Mr. THORPE. My reading of it is that AmeriCare, other than public sponsorship, looks just like a private health insurance plan. So it really is not comparable to Medicaid for a lot of the reasons that Professor Davis has just pointed out, first; and second, it is not a welfare-based program. It really is a mainstream, private insurance-type health insurance program that happens to have a public sponsor.

The CHAIRMAN. On cost containment, I think we all understand that whatever we do in terms of access, we have to have an effective cost containment program. I am wondering, Ms. Davis and Mr. Thorpe, what reaction you have to whether you think we can make meaningful progress in terms of effective cost containment with this program.

Ms. DAVIS. Certainly, I think the experience of other countries gives us good reason to believe that this type of mechanism would be effective. The U.S. to date has relied on things such as Mr. Butler favors, like out-of-pocket spending. In the U.S., Americans spend 25 percent of all health care bills directly out-of-pocket. In Germany it is 7 percent. In the UK it is 3 percent. So we spend much more out-of-pocket by patients than any other country, and yet if you look at the percent of gross national product going for health care, the U.S. is the highest at 12 percent versus about 8 percent in Germany and 5 or 6 percent in the UK. So certainly, those systems that have had a major role for government in setting or negotiating provider payment rates, that have set up global budgets or expenditure ceilings or expenditure targets, have a record of being able to control cost. Whereas our system of just leaving it to patient incentives has been totally ineffective at controlling cost.

I might point out, for example, in the case of prescription drugs in the U.S. that that is the least insured benefit and one of the most rapidly growing cost items. So there is no evidence that having patients socked with the bill is in itself an effective mechanism for controlling cost.

The CHAIRMAN. My time is up, but Mr. Butler I want to give you assurance I will be back to you in the next round.

Senator Hatch, I think I'll go over and vote, and when you've concluded, you can recess while you vote, and we'll come back.

Senator HATCH. Thank you, Mr. Chairman.

Dr. Davis, I am concerned by your testimony that really, if you had the opportunity you would really recommend national health insurance; is that correct?

Ms. DAVIS. I strongly support universal health insurance covering every American under a health insurance plan, whether it is a public plan or a private health insurance plan. Back in the 1970's when we used the phrase "national health insurance" we meant,

for example, requiring employers to provide private health insurance——

Senator HATCH. So you'd be happy if the government provided a massive national health insurance program.

Ms. DAVIS. I don't think it has to be a single public plan. A single public plan has certain advantages, like——

Senator HATCH. If you had your preference—you seem to think the government has a lot of efficiencies that would help make the system work fair for everybody across-the-board.

Ms. DAVIS. I do think it has a lot of efficiencies and lower administrative costs in terms of progressive financing through taxes. In terms of what I have personally written about, I have supported the type of plan that HealthAmerica is talking about, giving employers the choice of private insurance coverage or public plan coverage.

The advantage of that is it minimizes the additional Federal revenues that are required to finance it; it minimizes any disruption in current sources of payment. Currently, employers spend $175 billion or so on health insurance. It would maintain that. We have 158 million people covered under private insurance; if those people want to continue that, if employers want to continue that, they can do it. Everybody is assured. They can't be worse off under this system because they can always continue their current private health insurance coverage.

So I think that a mixed system such as the one we're seeing here is the most pragmatic way to go. That's not to say there aren't advantages of a single public plan. And if we had done that in 1950 when our private health insurance industry was a $1 billion industry, it might have been more feasible than when you are talking about a system where employers are already buying private health insurance for the bulk of American workers.

Senator HATCH. Mr. Butler, do you agree with that?

Mr. BUTLER. Well, for the reasons I mentioned, I don't think that this kind of hybrid system is indeed stable, because I think there will be adverse selection against the public system.

The very fact that the public aspect, AmeriCare, in this proposal is indeed far better than Medicaid and is comparable to private plans currently operated by corporations, I think will make it more likely in fact that there will be a shifting, a cost shifting if you like, or a risk shifting is the more important point, from the employer-provided coverage to that publicly-provided coverage. I think that will go on.

Senator HATCH. Do you agree with Dr. Thorpe's threshold figures of $19,200 in earnings?

Mr. BUTLER. I think these kinds of threshold figures and indeed any estimates of what the likely shifting is going to be are very, very difficult to determine because they are influenced by many, many different factors.

As I alluded to in my testimony, the risk of litigation in private firms, if a private firm operates its own insurance coverage, it now under this legislation will risk litigation if it denies employment to a certain individual.

Senator HATCH. So it's a lot simpler to just pay the 7 percent and forget about it.

Mr. BUTLER. I was just about to say that; that therefore in that kind of situation it would make eminent sense to simply just—I used the term "dump", which Dr. Davis doesn't particularly care for—but certainly, "shift"——

Senator HATCH. Well, it is an insensitive term.

Mr. BUTLER. Well, I agree. But I just want to make it very clear that the word "dumping" which we used in terms of DRG's in hospitals was well-used in this committee and elsewhere, and I think we'd be talking about exactly the same kind of process.

Senator HATCH. I heard one estimate that if you use a threshold of $19,200 or thereabouts that you would literally, to use your term, "dump" 60 percent of the employees in America into the 7 percent program.

Mr. BUTLER. I think it is not inconceivable. I think there will be far more people shifted into the public program, while still employed, than the estimates tend to indicate.

Senator HATCH. Some have been indelicate enough to call that a Federal health care program.

Mr. BUTLER. I would simply characterize it this way. It is a program where the Federal Government is at risk, depending on decisions made by private employers.

Senator HATCH. Why is that? The private employers will have to pay 7 percent. Why would the Federal Government be at risk?

Mr. BUTLER. Because what the Federal Government risks is the health characteristics of people whom employers decide to place into the public program and pay the 7 percent tax. It faces the prospect of that risk being much higher in terms of medical costs.

Senator HATCH. So you question whether the 7 percent paid into the Federal Government will really pay the cost for these people.

Mr. BUTLER. Certainly, I certainly do.

Senator HATCH. Do you have any doubt that it will not?

Mr. BUTLER. I really have very little doubt that it will not.

Senator HATCH. I don't think anybody has any doubt that it will not. Well, who is going to pay the additional costs for their health care, then?

Mr. BUTLER. Well, I guess the Congress of the United States will figure that one out.

Senator HATCH. But we don't have any money. Where are we going to get the additional moneys to pay the additional costs?

Mr. BUTLER. Well, either you will have to raise the payroll tax——

Senator HATCH. Do you mean they would ask us for another tax on top of already 7 percent on small business?

Mr. BUTLER. That would be the implication if the dynamic is as I suggest.

Senator HATCH. I know Senator Kennedy could not possibly want that as an outcome here.

Mr. BUTLER. I am sure you are correct, Senator Hatch.

Senator HATCH. But I have no doubt that that is what is going to happen. And what about those businesses that can't afford to pay the 7 percent; what happens to them? Of course, they are going to have a 5-year phase in period.

The CHAIRMAN. What about a little surtax on millionaires; do you object to that, too?

Senator HATCH. What about that, Mr. Butler? Would a little surtax on millionaires solve the problem? How about a big surtax on millionaires; would that solve the problem?

The CHAIRMAN. Ten percent above a million is $7.6 billion.

Senator HATCH. Let's make it 25. Let's not be cheap here.

Mr. BUTLER. It's up to you to determine those kinds of figures. The point I'm making is that——

Senator HATCH. You and I both know that that won't solve the problem.

Mr. BUTLER. It will not solve the problem, but it points out the fact that the notion of a 7 percent tax paying for the public program, I think is naive, quite frankly.

Senator HATCH. Well, it seems to me it is not only naive, but you make all these businesses pay 7 percent within a phase-in period of time, some of which will just not be able to and will have to go out of business; you then saddle them with employer sanctions that literally guarantee there is going to be all kind of litigation for people who are turned down for employment——

Mr. BUTLER. Absolutely.

Senator HATCH [continuing]. Then you require them to pay the 7 percent, which clearly is inadequate for those who will be dumped into this Federal welfare medical care system, who of course are going to be the ones who are the most expensive in most cases, so the funds will be inadequate to take care of them—and lo and behold, all we have left, since we don't have any money in the Federal Government, is that we're going to have to tax the American people more—and not just the rich. If you tax the rich 50 percent of their income over $1 million, you still wouldn't have enough money to run this system, so you are still going to have to tax the America people. So this is just another backdoor way that ultimately we're going to have to go to more taxation to pay for a health care system that, it seems to me, is going to have difficulties anyway because if we dump this all on the Federal Government, I think we are even less capable of rejecting demands by the public than State legislators are.

Senator DURENBERGER. Orrin has only been on the Finance Committee for 2 weeks, and already he is raising taxes.

Senator HATCH. Not I. Senator Kennedy loves taxes, but I know he doesn't want to raise taxes beyond the 7 percent. It used to be 8 percent; I thought that was a little more honest than the 7 percent.

Now, am I missing something here?

Mr. BUTLER. I don't think you are at all, Senator. And I would just also emphasize——

Senator HATCH. Well, Senator Kennedy isn't missing it, is he?

The CHAIRMAN. No.

Mr. BUTLER. I would also emphasize that the decision as to what the cost of the public program will be, the AmeriCare program, is in fact in the hands of employers making a decision in their own interest. They make the calculation—do they think the cost of covering somebody is greater or less than the payroll tax. If they think it is greater, their tendency will be to shift those individuals into the public program, and therefore——

Senator HATCH. That might even include some fairly large businesses.

Mr. BUTLER. Large or small. Clearly, in the case of smaller businesses, which in general do tend to face higher insurance costs and overhead——

Senator HATCH. Well, the large businesses benefit from AmeriCare more than the small businesses, don't they?

Mr. BUTLER. Many will.

Senator HATCH. They're glad to have it because they're already paying through the nose.

Mr. BUTLER. There are indeed many large corporations you know that strongly favor taking health care out of the hands of corporate benefit——

Senator HATCH. And you criticize the current system which allows exotic health care programs that are $8,000 to $12,000 a year, with total deductibility, where the poor little small businessperson has 25 percent deductibility at the most; is that right?

Mr. BUTLER. That's right.

Senator HATCH. So if we want to be fair, wouldn't it be good to try to resolve that problem?

Mr. BUTLER. Senator, that's the heart of the kind of proposal that we are putting forward.

Senator HATCH. Well, I thought you were. I kind of got that impression. It seems to me that if we are going to have a program that really leads to increased taxes, we ought to just have the guts to do it. But that doesn't seem to be the answer if we throw everything into the Federal Government where we have the least capability of standing firm against costs—much less than State legislators, in my opinion, and they aren't great—like Maryland, with 31 mandates; and every other State has a certain amount of mandates.

The CHAIRMAN. I think your time is up.

Senator HATCH. Is my time up already? I was just getting to enjoy this.

The CHAIRMAN. Mr. Butler, you've almost convinced me to just go back to a mandated program that won't cost the taxpayers anything and will cover 24 million Americans.

Senator HATCH. That's what he really wanted to do at the beginning.

The CHAIRMAN. You just can't have it both ways. You can't say, "We don't want to spend anything. We want a mandated program." We passed that out last year, and you said, "What are we going to do about all those who aren't covered?" Now we've got one that is going to cover them, and you say, "Why are we covering all those? Someone is going to have to pay for it."

You know, you begin to meet yourself around the bend on some of these arguments. [Laughter.]

Senator HATCH. Why don't you answer that, Mr. Butler?

The CHAIRMAN. We're about to miss the vote, Senator. We'll have to recess.

Senator HATCH. I'd like him to answer that question, though, and I hope you'll give him that opportunity when we come back.

The CHAIRMAN. The committee stands in recess.

[Recess.]

Senator HATCH. If we could resume, let me just ask a couple more questions until Senator Kennedy gets here.

Mr. Butler, Dr. Davis has more confidence in the Federal Government on national price maintenance than I do. Do you have any confidence that if we did a national health insurance approach—which it seems to me this would get you to pretty fast, because even big businesses would want to dump it on the government after a while—do you think that we would be able to have a better system than we have even today?

Mr. BUTLER. That's a very difficult question. As I mentioned, I lived under the British system which does have a fixed budget, with the government as an all-payer, essentially, for all except 10 percent, which is in the private sector; and indeed it holds costs down compared with this country. There may be other factors, and we must bear that in mind, but it does so with very explicit techniques that may not be attractive in this country. It denies service to people, for example.

Senator HATCH. It sure does.

Mr. BUTLER. The Canadian system does the same. It uses waiting lists. It uses a slow introduction of technology.

So in answer to your question what I would say is that the government cannot maintain the same level of services and improvements of services that Americans have in general grown accustomed to, whilst trying to hold down costs and total expenditures. That is what is an impossible dilemma for it to face. So it will go one way or the other—either it will not hold down costs—and with all due respect to Dr. Davis, I think if you look at the projections for Medicare when it was first developed in the 1960's, they bear little relation to the costs today. Moreover, you do see in Medicare a widening of cost controls—first, DRG's, now RVS and so forth—as I suggested would happen under this system. Either you lose control or else you deny service, one of the two.

Senator HATCH. While you are on that point, what is the evidence that rate regulation such as the proposed national expenditure targets of this bill works in this country in health care?

Mr. BUTLER. Works in this country?

Senator HATCH. Sure.

Mr. BUTLER. I don't know that we have any evidence, really——

Senator HATCH. Well, let's put it in any country—but we're really talking about our country.

Mr. BUTLER. I think clearly if you fix a budget, and you simply say there will be no more spent than this, if you can really hold the line on that budget, which arguably the Canadians and the British have done, not completely successfully, you can do it if you stop consumers demanding services. If you don't do that, you cannot control it, and that is the inherent problem, I think, today with Medicare and Medicaid. It is not a problem in Canada because they simply shut down beds available, as they do in Britain and so forth.

But if you are trying to maintain the current system in the U.S. of choice, of people able to trigger health services by their own decisions, and you have a fixed budget, then it is an impossible combination.

Senator HATCH. Do you have any belief that this Congress of the United States is going to do that?

Mr. BUTLER. No—hold the line on the budget?

Senator HATCH. That's right.

Mr. BUTLER. Certainly not.

Senator HATCH. I have zero belief. We have people right on this committee who are going to come up with all kinds of ways of spending, knowing that the Congress as a whole cannot even fund what we are doing now.

Ms. DAVIS. If I could interject on this issue of the evidence of rate regulation working in the U.S., I think Mr. Reischauer of the Congressional Budget Office in his testimony before the Ways and Means Committee last July the 11th mentioned the experience of hospital all-payer rate-setting in States such as the one I am in, Maryland, and indicated that evaluation of these systems has lowered costs by 2 percent to 13 percent-plus initially. So they had a first effect of setting costs——

Senator HATCH. Oh, there is no question about that.

Ms. DAVIS [continuing]. And they cut the rate of growth in hospital spending substantially below what would otherwise have occurred.

So I think we do have experience with rate-setting in the U.S. We have experience that it works to cut costs, that it doesn't lead to waiting 5 years for surgery and so on, doesn't lead to lower-quality care, doesn't lead to reduced new technology.

Senator HATCH. Mr. Butler.

Mr. BUTLER. But it does lead to cost-shifting, which is precisely what has happened with these hospital rate regulations. That's what happened on the DRG's——

Senator HATCH. And who is paying for that, Mr. Butler?

Ms. DAVIS. Well, in these systems, they are not——

Senator HATCH. Well, let me ask Mr. Butler who is paying for the cost-shifting.

Mr. BUTLER. In the case of Medicare, it is the Federal Government through the Part B, when the shifting was from hospitals to physician payments, which is the reaction; in the case of other types of cost-shifting, it is private insurance plans.

Ms. DAVIS. Yes, but these plans are all-payer systems; there are systems that private insurance——

Senator HATCH. But you also have to say it is the individual hospital and providers as well——

Mr. BUTLER. In the case of some.

Senator HATCH. The University of Utah loses $40 million a year on uncompensated care.

Mr. BUTLER. That's true.

Senator HATCH. So it is nice to talk in the generalities that Dr. Davis is talking in, but in the real world—which is what I'm talking about—this cost-shifting is a pretty big thing, isn't it?

Mr. BUTLER. Absolutely.

Senator HATCH. It is not something you ignore and say, "Oh, these rate regulations really work."

Mr. BUTLER. That's precisely why I made my argument that this is an unstable solution, the Mitchell bill, because it cannot achieve the objectives——

Senator HATCH. Well, let me just ask one more question because I know my time is up. But one last question: What would you do?

Mr. BUTLER. I'd have a debate between maybe Senator Wellstone's ideas and a system which tries to bring in a very different kind of cost control, the cost control that applies throughout the rest of the economy, which is a consumer facing certain options and acting in his own self-interest. It is the self-interest of the consumer balancing costs and benefits which is more likely to lead to an economical result, I believe, than somebody else making those decisions with a very different bottom line and different perspective.

I would argue that, let's face it, in Canada and in Britain, those systems are popular with people there. I don't think they would be popular in this country. But it seems to me that that is an alternative approach that is worth exploring. I think it will be rejected and should be rejected, but it is at least a system which holds costs down in certain ways, with certain side effects.

I suggest an alternative, as I have alluded to in my testimony. But those are systems, it seems to me, that are based on a set of dynamics that make some sense given the way other systems have operated. I'm not sure that the Mitchell bill does.

Senator HATCH. Let me just ask two other questions. Do you believe our current Federal programs are efficient, and do you believe more Americans want to get their health care services from public providers—or, public programs.

Mr. BUTLER. I certainly don't believe they are efficient. Generally, from the surveys I have seen, Americans are concerned about costs associated with health care; they are concerned particularly also about the paper work and complexity, and that is what causes them to be attracted to proposals like the Canadian system. But remember that the Canadian system has generally been advertised as just like the American system, with complete choice and available technology, but it doesn't cost you anything. I must admit that I would be attracted to that system if indeed it could exist.

Senator HATCH. I think I've taken too much time. I'm sure Senator Wellstone has some questions.

Senator WELLSTONE. No, I don't think you took up too much time. I think the questions were important.

Let me get back to some of the concerns raised by Senator Hatch, and I hope that Stuart Butler and I can have some discussion about the internal logic of this and where it goes. But I'd like to start out with Karen Davis, if that's okay, because I was very interested in several things that you said.

One of the points that you made is that as you look at this comparatively, you see a very strong correlation between cost containment—and we've been talking about cost containment—and strong government roles set in negotiating provider payment.

Now, what I'd like to ask you is what do you think would be the potential cost savings in this particular piece of legislation that we're looking at today if we were to give the Federal Health Expenditure Board created by this legislation more power to actually enforce its decisions—in other words, right now its powers are "advisory"; in other words, the power to enforce health care budgets and fee schedules—what would be your estimate about how much money we might be able to save and how effective this would be by

way of cost control? I think this is one very central issue in this whole discussion.

Ms. DAVIS. As I indicated to Senator Hatch, I think there is a lot of evidence that all-payer rate-setting, expenditure targets, expenditure ceilings, global budgets can slow the rate of increase in health care spending. Certainly something on the order of 3 percent a year when you are talking about a health system that is $1 trillion is certainly very substantial savings.

In terms of what the evidence is from the international experience, I'd draw your attention, for example, to what has been done in Germany with physician services. Beginning in 1977, they set a target for total expenditures on physician services, and that slowed down the rate of increase in spending on physician services. Physicians went from being paid six times what the average worker was paid to being paid more like three and a half, four times what the average worker was paid, so it did slow down spending in that area very substantially. In 1985, they went to expenditure ceilings, and as Professor Thorpe mentioned, they tied the increase in spending on physician services to earnings growth so that the payroll tax would not go up over time, and they succeeded at that.

So certainly I think all of these measures work. Expenditure targets have been documented to work. Expenditure ceilings have been documented to work. So I think there is a lot of merit in establishing this board, either setting or negotiating provider payment rates, but really deciding prospectively that this is the amount we are going to spend on health services across-the-board.

Senator WELLSTONE. Senator Hatch talked about the real world. In the real world, people are very tired of medical bills they can't afford. In the real world, people are wondering about what many call the "medical arms race" and whether there is going to be any accountability. In the real world, people are very angry about health care costs. In the real world, this is becoming a central issue in every family's budget. So when we look at this whole question of cost control, do you think we should move from an advisory role to more enforcement powers on fee schedules or not, in terms of what we really need to do to have some cost control. Otherwise, more and more money pumped into a system with no cost control, no accountability, and I worry about where it all goes.

Ms. DAVIS. I absolutely agree that in the real world, people are concerned about health care costs. The 33 million people without any health insurance are the ones who are causing that $40 million of uncompensated care in Utah; it is causing the $6 billion of uncompensated care nationwide. We have to provide health insurance coverage to the population if we are going to provide adequate financing to the hospitals and other providers that provide their services.

This approach is the one that fills the gaps in insurance coverage while having the least impact on the Federal budget. In terms of going further with the National Expenditure Board, I think it is worthwhile trying expenditure targets. With regard to the Medicare program, for physician services, we set it up on an expenditure target basis. Every year we set a prospective target. If that is exceeded, one can take it out of fees in a subsequent year.

I think the nature of our legislative process is that we don't have just a one-time chance to do it one way. We can start with targets. Certainly there is evidence from Germany and other countries that have tried this that that will work. If we need to then give it more teeth and say that that's going to be an expenditure ceiling, and it is going to be binding concurrently, one can move to that, but one doesn't have to do that immediately.

Senator WELLSTONE. Thank you very much.

Let me ask Ken Thorpe a very similar question if I could, because I am very interested in this Health Expenditure Board and where it fits in. There are so many aspects of your testimony to pick up on—it was excellent—and I apologize for just picking one point, but I know there is only a limited amount of time.

Ken, you testified that one of the most important aspects as you see it of this legislation is the establishment of this Health Expenditure Board, and you further went on to say that you think that impressive reductions could be achieved if this board's powers could be binding rather than "voluntary".

So I would like to ask you since the focus today is on the economic impact, what do you see as the potential savings if the powers of the board were binding—they are not right now.

Mr. THORPE. If you look at Table 6 in my written testimony, I did a very simple calculation. I simply assumed that the rate of increase in health care costs went up at about the rate of what we have observed since the late 1970's in the all-payer rate-setting States—New Jersey, Maryland, Massachusetts and New York. So that's just a two percentage point difference in the rate of increase. And again that's about what the differential is in those States relative to the national average. And you don't have to go out very far to see with that rate of growth that the savings, if you will, to the economy are very substantial, and they really are savings because they are things that we can now spend on other consumption items; they are things that individuals are now paying out-of-pocket, and they can actually save money, which can be used for economic investment and growth. So we are talking about something on the order of $500 billion, by the year 2000. That's a very substantial divergence.

Senator WELLSTONE. Quickly, would your policy prescription be then for the powers of the Health Expenditure Board to be binding in the level of policy desirability?

Mr. THORPE. I think that you might get there. What you've done is very important here. One is that you've provided, I think, a mechanism to eliminate cost-shifting, which is really central in this debate, both because there is no more uncompensated care and second, because you would over time align payment rates across providers. So you have developed a mechanism where we can learn how to do this. There is going to be a lot of learning here. You have the mechanism in place. It is in the current version of the bill voluntary. I think it will provide a very strong basis to start looking at a national cost containment approach.

Senator WELLSTONE. The last point—and I hope Mr. Butler has some time to respond to this—I guess since I have run out of time, I would only say that I find it interesting that both of us see some internal logic, if you will, to one or two alternatives, one of them

being the consumer sovereignty model, consumer accountability model, that you have presented. And I have questions about that, in part because I think individuals are having a heck of a time with insurance companies right now, quite frankly, without the advantages of community rating and so on, and I don't see anything in there by way of how you reform insurance companies and how you deal with the costs. That to me is a terribly difficult problem.

The other thing is I fear high deductibles and co-insurance payment requirements in terms of the regressive effects.

So I'd just say to you that I think there is an internal logic. It is just that I think the direction you want to go in is one that I have many questions about, and obviously the direction I think we should go in, I have very few questions about. Anyway, I'd like your comments, quickly.

Mr. BUTLER. Well, I think you are right—without getting into a debate over the relative merits of those two systems, and indeed I think what Dr. Thorpe said I agree with in the sense that unless the Expenditure Board has very great powers, then the system in this legislation will fall victim to cost-shifting and all kinds of problems. If you, on the other hand, give it enormous powers, I feel those powers would have to be so widespread and so deep that it is indistinguishable from a government-run system, in which case why have the employer in this equation—the employer causes you a problem in this equation because he or she is going to make decisions, adverse selection decisions, if you like, against the public program. So therefore it would be in the interest of the government, if you want to go down that route, to blend the whole thing into a publicly-provided system.

That's what I mean by the inherent logic of it and the inherent illogic of the current legislation that we are discussing.

The CHAIRMAN. Thank you. The Senator's time has expired.

Just for clarification, is part of the reason that you believe the board might work because insurance would understand that if this doesn't work, a more dramatic and radical resolution of this issue might exist, and the providers might understand that as well? Do you think that there are forces in terms of real negotiation that would be present today that might not have existed at another time?

Ms. DAVIS. I think the threat of legislation, of stronger teeth, can be a very effective deterrent. I'd refer, for example, to the experience that you are very familiar with in the late 1970's when the Carter administration proposed hospital cost containment with mandatory legislation. While that bill was being considered in 1978 and 1979, there was a marked slowdown in the rate of increase in hospital costs. The industry mounted something called the voluntary effort, and they said we will hold down costs voluntarily.

So I think the threat that we'll try this, that we're going to have expenditure targets, that it won't necessarily be binding but will be voluntary, and we'll try to negotiate provider payment rates, but there is always that understanding that if that is not effective, then one can make those binding. And we have had the experience that as long as there is that threat that we could always move to mandatory ceilings, you can expect from that experience some slowdown in cost.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

Dr. Butler, you mentioned that at the heart of yours is the consumer determining services, and that through that, if I understand correctly, that will be in itself the cost containment mechanism, and the consumer will bring good judgment to bear on what he can or cannot afford. Is that correct?

Mr. BUTLER. As the basis of the system. It is not the entire system, but the underlying logic of the system, yes.

Senator KASSEBAUM. It seems to me that while there is much merit in what you say in your analysis, starting with the assumption that the consumer at this point is going to be able—all consumers, because I think you are considering "all" in the same category; there is not a different category for those who might not be able to understand actually how to pick and what they should pick—that seems to me to be the biggest concern. The elderly get very frightened, are very uncertain. The young are struggling with budgets now and don't know what might be. I think, going back to the real world, we would wish it would be that way, but it would take a lot of education, it seems to me, and a lot of time and patience to try to bring people into an understanding.

Mr. BUTLER. I don't disagree with your premise. I can make available more information on our proposal to you, but basically what we point out in the situation of, if you like, the confused or the ignorant consumer, or however you want to describe that consumer—and I don't dispute that at all—I think the issue is whether the consumer can elect to go with the advice or to join an organization which he or she feels is in his interest. And at the moment the only organization that you can join to get health care at a reasonable rate with tax relief is your employer. So you've got to hope that your employer is acting in your interests, including the other interests that the employer has.

If you had a situation where a confused consumer could, for instance, elect to join a plan run by a union or a plan run by a farm bureau and still have the same tax relief as one at the place of employment, then even an ill-informed consumer would be able to ask who do I trust most to make these detailed decisions for me. That is really the heart of the consumer choice in our proposal.

Senator KASSEBAUM. And then it would be the insurer who would set the limit.

Mr. BUTLER. The insurer may well set limits and may well insist on managed care, for example. I think many individuals in this country given the choice with a neutral tax system would in fact elect to join less costly managed care systems. I think the notion of people wanting to have choice at every element in treatment in this country is vast overrated, despite what the physicians tell us. I think most people are confused by that. They would go with their primary care physician as to what plan should I join, what should I look for, and that should be their choice.

Senator KASSEBAUM. Then let me ask you essentially, isn't the heart of that somewhat the Canadian plan, where you do have a certain limitation. In your case, you are assuming the consumer will provide that limitation with the health of the insurance company, and the Canadian Government, along with the providers in

the provincial system and the doctors and so forth, make that decision because there is only so much money that is available.

Mr. BUTLER. Yes, but in the Canadian system or the British system, the government essentially ultimately decides what services you shall have. My mother lives in Britain. She is almost 80. She is denied services because it is not efficient to provide them. Now, she cannot choose, unless she goes into the pure private sector, some other arrangement. She could under a consumer system decide to have certain services, may elect not to have others, or may elect not to be kept on life support systems. She could make decisions like that.

So I am just saying that when you come to these very difficult decisions, and you come to what services do I want, it seems to me that the consumer ultimately should have that choice—not a government official and not a health benefits manager for a corporation.

Senator KASSEBAUM. There have been some interesting stories recently, as you know, as far as life support systems and who does have a choice at that point.

Mr. BUTLER. Indeed.

Senator KASSEBAUM. Dr. Davis and Dr. Thorpe, do you believe that that would work? I guess I think the importance of these debates, Mr. Chairman, is that we are sort of trying to struggle with some of the important issues here to come up with what we would hope would be an answer to our health care problems because I think we all join together in recognizing there is a real problem.

Ms. DAVIS. I think you raise some very good concerns about the consumer's inability to really evaluate the claims that insurers may make about their products. I think a good example is turning to the Medigap supplemental policies that many elderly Medicare beneficiaries buy. We certainly have seen a lot of abuses in that sector where somebody might be talked into buying 30 policies that duplicate coverage.

I am very concerned about Mr. Butler's plan, replacing largely employer-provided group insurance, replacing programs that work like Medicare and instead relying on the weakest reed in our whole health care financing system, namely, individual insurance, where we know that premiums are adding 30 to 50 percent for administrative costs, where the policies are generally inadequate, where consumers are not able to make informed choices about what is a good plan for good value.

So I think it is very naive for Mr. Butler to say, well, the farm bureau could offer an insurance plan, and if people trusted the farm bureau, they could buy from them. What we have seen is a lot of abuse in this industry—it has required government regulation to try to eliminate the abuse.

So I think we do need to build on the strongest parts of the health care system—programs like Medicare, programs like good, large employer private health insurance plans—and use that as the model, not to rely on individual tax credits to purchase individual insurance that are the very worst example of what we have in this country.

Senator KASSEBAUM. Just to move for a moment on to another aspect, one-fourth of every health care dollar I believe is estimated

to go into administrative costs and paper work. I think this is something that is frustrating to everyone. And there are some provisions in S. 1227 that would have standardized forms and would I think move to try and correct that.

The Canadian system supposedly, because of it being a single payer, purports to be a savings in that area. Do you think it is?

Ms. DAVIS. I think in terms of the actual numbers on administrative costs, it is not one-fourth, but $25 billion to $30 billion, if you really look at the national health account; about 5 percent goes for administration. Certainly in the small group plans, you get administrative costs at 25 percent. Then in programs like Medicare and Medicaid, they run 2 percent. But whatever the numbers are, the question is could a single public plan have lower administrative costs.

There is no question that if you enrolled in one plan and stayed with it for life, that is lower administrative cost. If you've got one claims form, that is lower administrative cost, instead of 1,000 different insurance companies. If you've got a budget for a hospital so they don't have to itemize for every piece of kleenex or whatever that the patient has, it is lower administrative cost.

But I think this particular HealthAmerica bill is a pragmatic approach to reducing those administrative costs. It would build on large employer plans. It would lead to a single claims form, uniform billing procedures. To the extent that people went into AmeriCare, you'd have very low administrative costs because you are not paying commissions, you are not advertising. The government is not advertising to get people to sign up for AmeriCare. You've got very low administrative costs in the public programs.

Senator KASSEBAUM. I guess S. 1227, like many proposals that we all tend to move toward—except perhaps the Heritage's is certainly different—only works off the status quo. And it just gets frustrating, and I just think we've got to spend a lot of time trying to figure out if that is what we really want to do, or if we want to try and sort of wipe the slate clean and start with something else. Getting there and trying to figure out what it is is the hard part. But I have certainly valued hearing the comments of all three. Thank you.

The CHAIRMAN. Thank you, Senator Kassebaum.

Senator Simon.

Senator SIMON. Thank you.

"The real world" is the new phrase for our hearing today, I think. Let me take you to the theoretical world. I'm going to vote for this, but let's just say in theory that you had a choice of the Canadian system or this legislation. Which would you vote for, if I may ask the three of you?

Ms. DAVIS. I think if it is 1991, the HealthAmerica approach of a mixed public-private, "pay or play" type of option is the one I would vote for. If you asked me that question in 1950, before we had the growth of a private health insurance industry, when it was a $1 billion industry, not a $200 billion industry, and asked would a single public plan have a lot of merit, I would agree with you on that.

I think just starting from a system where we've already got a tradition of major private health insurance through employment-

based, it would be economically disruptive to abolish overnight a $200 billion industry, to take the $175 billion that employers pay, and somehow convert that all into new Federal budgetary outlays.

So if you ask me where I am, pragmatically, starting from what we've got in 1991, I would say this approach is of merit.

Senator SIMON. And now we are really getting theoretical. What if I were to ask you that question in 1996; how do you think you would answer it?

Ms. DAVIS. I think if we don't do anything until 1996, and we continue to have the kind of health care cost explosion we have, the growing numbers of uninsured, the increasing underwriting practices in the insurance that exclude people who are a bad risk—today 30 percent of people with AIDS have no insurance at all, 40 percent have to rely on Medicaid, only 30 percent are covered by private insurance, and once there is genetic screening, you can find out not only who is at risk for HIV disease, but who is at risk for all kinds of hereditary conditions—every American is at risk of not being able to get coverage because there is something in their make-up or history or risk that would make them uninsurable.

So if you are talking about 1996, and we continue down this path of exploding costs, rising numbers of uninsured, sorting out the bad risks and leaving them on their own, then I think the only answer is going to be a very drastic approach of eliminating the private health insurance industry and going to this.

So I think it is very important that we move now to address these problems that are already very serious and to try to have a workable system of a mixed public-private system.

Senator SIMON. Mr. Thorpe.

Mr. THORPE. I think I would agree with that, with two footnotes. The first one would be some understanding of how it would be financed, that is, how the Canadian system would be financed. It is not clear to me—I have tried to theoretically generate the money required to redirect private expenditures through the public system—and it is (a) very hard to do, and (b) I still haven't made it more progressive than what we have now. So that is a big issue of how it is financed and how you could ever rechannel, even though that money is allegedly all in the system, but you are rechannelling private money through the public sector, and it is not at all clear to me that we can make it more progressive than we have now.

I guess the second point would be that the dislocations, depending on how this was phased in, and the distributional swings in the economy would be, I think, so extreme, exactly for the reasons that Professor Davis has mentioned, that I think in the short term it would do a lot more harm than good.

But I probably would agree that had we had a choice 40 years ago of where to go, where we would have really minimized the distributional effects of moving in that direction as opposed to the direction that we ultimately went, that that might have been a better choice.

Senator SIMON. Mr. Butler.

Mr. BUTLER. You have given me two unpalatable alternatives, Senator, but given those, I would in fact choose to vote for the Canadian system for two reasons. One is that I think the second

system, as I said, would eventually evolve along that direction anyway, so given that, I would prefer to go there and deal with it. The second reason is that I think as an individual I would be able to work within the system and to, if you like, manipulate the Canadian system to my advantage, much as many Canadians do, as I'm sure you know. There are ways of jumping the queue. There is the United States nearby, if you want to go that route. People come to Detroit, people come to Seattle and so forth for surgery—in other words, somebody who appreciates how bureaucracy works, as I think I do, maybe more than some people, would find the Canadian system a system they could work with. That is now true of the average person.

So I think given that choice, that's what I would do.

Senator SIMON. Ms. Davis, there was just one item in your testimony that I did not understand. You say, "Spending by households would fall by an estimate $23 billion. This includes a reduction of $8 billion in premium payments. In addition, out-of-pocket expenditures would fall by an estimated $15 billion." What do you mean by "out-of-pocket expenditures" and how does that differ from household expenditures?

Ms. DAVIS. Usually when I refer to "out-of-pocket" I am talking about deductibles, co-insurance if you have insurance, or if you don't have insurance, paying the bill. When I refer to household expenditures, typically I am including premiums, either the premiums that might be paid to the Medicare program or that might be paid to private insurance. I don't know whether Mr. Thorpe wants to—I think he also referred to that.

Mr. THORPE. Yes, I guess I am guilty here. What they refer to are two things. On private premiums, the reduction is due to the fact that a lot of people currently finance all of their health care outside of the work force by buying individual policies. Under this proposal, they would at most have to pay 20 percent of a premium, so there would be reductions there in premium payments.

Out-of-pocket again is just how to categorize this. There are two sources of reductions in out-of-pocket. One is that the uninsured will now be insured, and by definition we have made estimates of how much less they would spend out-of-pocket. And second, even individuals who currently have insufficient health insurance would have this basic benefit package and would spend less out-of-pocket on medical care services.

Senator SIMON. Thank you. As I told the chairman when we were walking over from the vote, I am impressed by all three witnesses here today. Thank you.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you.

In response to my colleague from Illinois' question, I think you'd have to invoke cloture on my response to that one—but I guess that's what makes this a very healthy debate. I didn't hear all of it, and I particularly enjoyed the series of questions that my colleague, the ranking member of this committee, asked because I think it set a framework for sort of the third course in this entire debate.

But I express my gratitude to all of the members of this panel not only for what they are saying today—most of which I don't

agree with—but for the contributions that they have all made over the course of my service here in the Senate, and to thank them for the comments that they made about the chairman of this committee, who has been trying for 30 years or something like that—I don't want to age him—to get us to do something about a problem that has been obvious to him longer than it has been obvious to us.

My first question—and I know we've got economists here, and I am not one, so I don't know how to ask these questions, but somewhere between economics and politics, I suppose you'll find the realities here—but my first question is if the point we are debating here is universal access, and this is the one thing the Democrats are offering us that Republicans have not been able to come to grips with, and that is any one of the Democrat plans you look at provides you with universal access. You can say to every American if we enact one of these plans, that everyone will have whatever universal access is. Whether you go to Canada or you go to Massachusetts, employer "pay or play", you've got taxes.

We can't come up with that. We say it is because we are too responsible, and we want to pay for it, and all that. But in part I think it is because we haven't agreed on the "what"—what is it? Universal access to what?

As I begin my thinking on that process, I think of two things. One is health, and the other is medical services. I think we know that in America we've got a mixed system for health pretty much because a lot of it we buy because the public health service tells you we have to be immunized and so on. So we are buying it in the community, we are buying it at school. The government is there to help us directly with a lot of that. But also we use insurance or private pay to get some of this from our private docs.

While that is a big problem and it needs to be dealt with, I think most of what I hear is dealing with the medical side—the docs and the hospitals when I am sick, when I am injured, when I am dying.

The way I look at this kind of goes like this if I'm dealing with what Paul Wellstone said about fear. The problem is that we used to be able to go to the doctor or the hospital with our check book, and if we didn't have a check book it didn't make any difference because the bill got added to somebody else's, and they paid for it with their check book. Today there are very few folks who can take their check book, and in fact they don't take their check book to the hospital or to the doctor's office. They go there with a plastic card, which represents the "what" as they perceive it, I think—I think—and I need you to respond to this.

But our problem is that most people cannot afford to pay what they perceive to be the cost of medical services. So it strikes me that one of the definitions we need to come to grips with in this definition of "what" if we are going to get sincere about what we are doing with this bill is does the product that we're going to buy buy us access to payment for all of our medical services, or does it buy us access to financial peace of mind.

Is it financial protection, or is it a bill-paying service of some kind? My mother—who I always use as my epitome of the American public—when she calls me about Medigap once a year, medical supplemental, she tells me that my dad's toenails have to get clipped and all those things, and that is why she needs this particu-

lar brand of supplemental. And I say, "Mom, you know his toes are going to have to get clipped; why do you use your plastic card for that? Why do you buy another plastic card for that? You can use your check book."

But that is the way people have been taught to think in America. They think about the things that are predictable, so I've got to go and get health insurance for that—when I think it is supposed to be for the things that we fear, that we hope will never happen to us, and if they do, they are going to cost us so much money that we can't feed our kids and so on.

So maybe the first reaction from the panel could be what are we talking about when we talk about universal access. Should we talk first about financial peace of mind before we get to the provider payment?

Karen?

Ms. DAVIS. Well, I think you've raised a number of very good points. I certainly would agree with your point that we need to put more emphasis on prevention, whether it is public health approaches or covering preventive services such as immunizations, mammography, Pap smears, such as HealthAmerica would do.

I think you are right that no American today can afford to be without health insurance, and I don't know whether there was a day when you could go to a hospital with just your check book, but certainly today, if you have no check book, if you have no plastic card, there is no entry. So hospitals say either you've got insurance, or you write us a check for a pre-admission deposit of $4,000, or we can't take you. Mr. Butler has used the term "dumping". The only time I have seen the term "dumping" used is when you are uninsured, and a private hospital will not permit you to enter unless you are in a life-threatening and will die within 24-hours emergency situation. Otherwise, if you are just in labor with a baby, go find another hospital that will take care of you.

In terms of what is the objective of a universal health insurance plan, I think it is all three of the things you have talked about. I think it is access to care. Certainly there is evidence that the uninsured are much less likely to get prenatal care early in pregnancy. They are much less likely if they have high blood pressure to have regular hypertension screening.

We know that two-thirds of the uninsured have serious symptoms like bleeding, loss of consciousness, chest pains——

Senator DURENBERGER. I don't mean to interrupt you, but I think we're going to have to speed this up to hear from all three of you. But your answer is the important thing is all three——

Ms. DAVIS. So access is important, and financial protection for 60 million Americans who are at risk of paying huge percentages of their income if they get seriously ill, and the budgeting. I think having the employer contribute to the premium, having withholding for the employee's share of that premium also is a way of making this more affordable.

Senator DURENBERGER. Thanks very much. Ken.

Mr. THORPE. The other thing this does is it promotes access to medically necessary care. I think one of the under-advertised pieces of this act is the role that the Federal review board would have in coordinating, shepherding, and promoting medical care research at

a national level—the level I think personally where it should be done—doing technology assessment in a systematic and structured way, doing clinical trials when they are available and possible and affordable to do, and focusing research at a national level and its dissemination to physicians and others on medically effectively interventions. That's something we don't have now; we have it in a very fragmented way. We know it doesn't work—and you just have to look at the outcomes literature, look at the literature on appropriateness and so on.

So I think the benefit package is clearly important. More importantly probably is within the benefit package, what is medically necessary, and how can we provide that information to physicians. And having a national approach to this is very, very important.

Mr. BUTLER. I think it is almost impossible to answer you question, what are we trying to achieve, because it is not clear exactly what Americans do want out of the health care system. Certainly they want what we would loosely call medically necessary services, but that in itself is a very elastic concept if you look at different countries and so forth.

They also want the notion that they are not going to be bankrupted or heavily indebted by services, and hence the desire for insurance and also the attraction of simpler billing models, or nonbilling models, such as the Canadian or British system. So it is very clear that in some cases people are prepared to put up with what would be considered inferior services simply to avoid the cost aspects and the bill-paying aspects.

One final point I'd make with regard to your point about insurance at the beginning is that Americans are in a sense literally overinsured in exactly the way that you pointed out. One reason for that, of course, is that in order to get tax assistance for health care, you really have to have an insurance package through the place of work for most people. That means you want as much covered under insurance as you possibly can. So it is very often the situation where a less expensive and more efficient package, even with better services, would be available less expensively outside the place of work, and people will not choose it. Therefore even such a step as making out-of-pocket expenses more liberally treated under tax treatment might have an effect of reducing the insurance to genuinely large items, and that in itself could have a big impact on the overhead costs of insurers. I mean, it is very often the processing of these $5, $10, $50 claims, simply to get the tax relief, that is a very high element in the cost of insurance. So rationalizing that decision to very predictable and reasonable expenses, rationalizing that under the tax system might indeed have a big impact on the overhead cost of insurance.

Senator DURENBERGER. My time is up. Thank you very much.

[Prepared Statement of Senator Durenberger].

PREPARED STATEMENT OF SENATOR DURENBERGER

Thank you, Mr. Chairman, for holding this morning's hearing. Thank you also for your continued leadership in the health care arena. Despite my reservations about the HealthAmerica proposal,

I am pleased to see this committee move forward in its exploration of the legislation, particularly its economic ramifications.

Mr. Chairman, while we will hear otherwise from some of this morning's witnesses, I believe that the implications of HealthAmerica for our economy are potentially enormous, particularly—but not exclusively—for the small business community. We must thoroughly explore these implications, and—despite whatever differences of opinion we may hold on HealthAmerica—I look forward to the help that these expert health economists can give us in this exploration.

Mr. Chairman, HealthAmerica is a lengthy and complex piece of legislation. It would expand our current employment-based health insurance system by establishing a requirement for all employers to either provide their workers with health benefits—the so-called play option—or to pay for these benefits through a payroll tax contribution to a state fund. It would also replace certain portions of Medicaid with a new public program called AmeriCare. All Americans not covered by job-related health insurance would receive coverage under AmeriCare.

Mr. Chairman, over time, HealthAmerica would meet the policy objective of universal access to coverage for all Americans. At what cost, however, would that important goal be achieved? And who would pay the price?

Lest you or others here today think otherwise, I would be the first to acknowledge that there is plenty of room for improved efficiency in our current health care system. I would also concur that among some participants in our system we have allowed, perhaps even encouraged, what might be considered excessive profits. However, I want to make sure that any action we take to provide greater access to what is certainly the finest health care system in the world does not do irreparable damage to that system in the process.

Mr. Chairman, I am pleased to see the HealthAmerica legislation recognize the need to assist small employers in making the transition to universal coverage. In that regard there are certain aspects of your legislation that are similar, at least in intent, to measures I have introduced over the past few years. Among these are reform of the small group health insurance market and improved tax treatment of health insurance for the self-employed.

HealthAmerica also provides for a tax credit to help small businesses of marginal profitability afford health coverage for their employees, which I strongly support. The bill does not, however, stipulate how this credit would be financed.

Given the focus of economists on incentive-driven behavior, I will be curious to learn whether today's witnesses would support limiting the excludability from taxable income of employer-paid health benefits beyond those required to guarantee income security of employees. This should create positive incentives for consumers to control their spending, in addition to generating revenues from which to support such small business subsidies.

Mr. Chairman, there are many important issues to be examined this morning and in future hearings. I salute you for your perseverance and look forward to today's testimony.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

I certainly also want to join all of the other members of the committee who have commended you on raising these issues and trying to go forward. I strongly believe that at some point we've got to reach a consensus on where to go if we are every going to end up with a plan, and hopefully, we can work in that direction.

Like many others, we are trying to devise our own plan. I have studied the Canadian system, been there and spent a great deal of time trying to combine the present US system with the Canadian system, and we have what we call our "Medicore" plan which we are working on.

One of the areas that is of deepest concern as we move forward is how you make some more sense out of our present tax structure of incentives with respect to health care and whether or not we should move forward in sort of a large bandaid approach, which I would call this one—and it certainly has some advantages—without also taking a look at what we should be doing to restructure our present tax incentive programs so that they at least make some more sense. I am sure, as you all know, we have come forward with an anachronism of how to handle these things from World War II as a result of price controls and allowing certain corporations who at that time felt it advantageous to work with price controls to expand health coverage and to get a situation where it was tax-deductible to business but not income to the employee, which has built up very substantial inequities for the rest of the population.

We are trying to develop a system which will take care of those anachronisms and yet be equitable and also be advantageous to the employer-employee structure so that they can rebargain by pulling those costs out and financing them in some other direction.

So the first question I would ask is whether or not we should not be at this time, before we go too much further, re-examining our whole methodology for financing from the governmental perspective through tax incentives, etc, and making changes or trying to at least have goals for where we are going to end up, before we get into a system which starts now relying on a payroll tax, which may prove to be very advantageous but I must say I have some question as to how it is going to cover the costs at the 7 percent level, which in my judgment looks like it is less than half what it would be costing a present employer, and especially in the lower wage levels.

So that is my first question, and I would ask do you think we ought to be looking at this time at what are the goals we want to have for restructuring our tax system in order to provide more equity for the self-employed, employees of businesses that even end up with the 7 percent, whatever else, and not ignore those problems because they are politically difficult.

Karen.

Ms. DAVIS. I certainly would support things like letting the self-employed be able to deduct their health insurance premiums the way other employers do. I certainly think the 7 percent payroll tax in this proposal is a good way to structure the financing. It makes it more affordable for the low-wage firm.

Senator JEFFORDS. But will it cover the costs?

Ms. DAVIS. I think so. We're talking about 7 percent on the employer; there is another 1½ percent on the worker. You are talking about an average premium here of about $1,680. So you are talking about a combination of the employer-employee contribution that I think is going to be more than adequate to cover the costs. I have done my own estimates, and anywhere between 7 to 8 percent is within the ball park of what it would take to cover the actuarial costs of the type of benefit package that is in here.

The CHAIRMAN. If the Senator would yield on that point, then the rest of that is effectively the public cost?

Ms. DAVIS. Right.

The CHAIRMAN. So you could raise that up to 8 percent and have less on the public——

Senator JEFFORDS. That's what I'm trying to find out is what is the public cost.

The CHAIRMAN. The balance is trying to lessen the cost on small business, or you can raise it a little higher and make it more costly. These things change, and we are glad to get new information on it.

Ms. DAVIS. It is obviously the case that it will cover the costs for the average firm, but not necessarily for the low wage firm. If the average wage is $20,000 and you've got 7–8 percent, you've got, say, $16,000 per worker coming in, if you are a firm with a $10,000 average wage, and you are paying a 7–8 percent payroll tax, that is $700 or $800. That is not going to cover the cost. But that is the point—that's the group that is the most in need of public subsidies.

Senator JEFFORDS. Oh, I understand. I'm not saying they shouldn't be covered, but I don't think we should be unrealistic and not understanding that there is going to be a significant if not substantial increase in public participation in order to provide that coverage.

Ms. DAVIS. That's right. It is going to take new Federal moneys to solve the problem of 33 million uninsured. But 60 percent of people who are uninsured are poor or near-poor. They can't afford this. So you are going to have to have tax money, public moneys in some ways to pick up some of the costs.

Senator JEFFORDS. Right, I understand.

Ms. DAVIS. But I am saying it is quite modest when we're talking about a $700 billion health industry and when we're talking about a Federal budget in excess of $1 trillion. When you are talking about whatever it would take, on the order of $20–$25 billion, that is something that is affordable to pick this up.

The other point about tax incentives, I think many people who talk about tax incentives say that the employer contribution to health insurance ought to be taxable income to the worker. I know Mr. Butler in his testimony refers to that.

I think that the tax incentive that is there now has been what has led us to solve a great bulk of the problem of no insurance, so most employers do respond to that incentive for providing insurance to their workers.

So while we are the only Nation without a national health insurance system, if we didn't have these tax incentives, we'd be far worse than we are with 33 million uninsured.

To abolish that current incentive for employers to provide health insurance, I have some concerns about that. It means that you are making workers in the $20–$50,000 income range pay higher taxes. Now, Mr. Butler in his testimony says that tax break benefits the rich—but it is a flat dollar amount which is trivial to the millionaire or even somebody making $100,000 or $200,000; it is tiny.

So we always talk about taxes as progressive or regressive meaning as a percent of their income, and this current tax exclusion of employer contributions, if you were to repeal that, would hit very hard the working population between $20–$50,000 income.

Furthermore, the firm that now covers retirees under their employer plan, that has an older work force, that has a very sick work force, that employer premium is higher. And if you make the worker in that plant or that company pay taxes on that amount, you are going to disproportionately tax people who work in high-cost areas, in firms that have retiree coverage and sicker workers.

Senator JEFFORDS. So you think there is no merit to the argument that with this system we are placing our employers in a non-competitive world situation, and if we continue in this regard, that problem will increase?

Ms. DAVIS. I think it is important to control cost to help with our international competitive situation. I think it is important to limit the maximum employer cost to something like 7 percent that they can count on.

In terms of the firms that do not now cover their workers, most of those firms are not involved in international trade. You are talking about the service sector, retail trade——

Senator JEFFORDS. I know, but I am talking about the present tax incentive system which has gotten us into the position where we have huge health care costs in certain industries where everything is covered. You are talking about a very minimal package here of essential benefits or whatever versus the structure we have with some of our——

Ms. DAVIS. But the real problem is that we spend 12 percent of our GNP on health care, where Germany spends 8 percent and Japan 5 or 6 percent.

Senator JEFFORDS. Mr. Butler.

Mr. BUTLER. Well, I would agree with the thrust, I think, of your question, that the present tax system is quite inequitable in the way we are trying to help people. I understand, as Dr. Davis pointed out, that when you are talking about somebody with a very high income, the tax exclusion may be small potatoes compared with their income. But in terms of dollar amounts which could otherwise go to provide direct assistance to somebody without a package, they are significant amounts of money, and the fact is that somebody in the highest tax bracket gets the highest tax break under the current arrangement. So I think there is a very strong case for saying there should be reform in that area to restructure the existing tax system.

If we were to put a cap, for example, or some kind of income-related limit or something of that kind, it would yield significant amounts of money to enable the person who does not have coverage, for example, to go to an HMO or something like that and get some tax help for doing that.

Senator JEFFORDS. Let me ask you a quick question which will probably require a long answer. Under your plan, as I understand it, with the tax credit system to try to set up market incentives for searching out the insurance company that would give you the best rate, I have some concern as to whether you don't end up just searching for the insurance company that is the best risk group for your group so you can get the cheapest cost from it, and you still don't seem to do away with the costs incumbent with competition among insurance companies of advertising and so on, and that it isn't really going to work to select out the cheapest health care cost, but rather the best policy for your risk group.

Mr. BUTLER. As you said, it would require a very long answer to go into that. Maybe you can prevail upon the chairman to have some hearings specifically on our proposal. But let me just say that whilst in one sense you are correct, that with competition you do indeed have duplication and so forth, that is true throughout the economy. And the general argument that competition and duplication of advertising somehow is less efficient than a centrally-run system is something which I think in Eastern Europe they would laugh at, yet somehow it seems to be applied in health care.

The key about the health care problem in this country is really two key points—one, you have the issue of urgency and so forth associated with it. Second, you have the dilemma that you want price to be an incentive for people to shop wisely, if I may use that term—but you don't want it to be a barrier. And that is what our proposal is trying to bring about.

Senator JEFFORDS. Do you do anything about risk? Would you require all companies to cover all risks, or would you allow them to select risk?

Mr. BUTLER. I would suggest that they cover all risk, and I do it for this reason, that you can basically cross-subsidize in two ways. You can put a premium that underestimates the risk and cross-subsidize in that way—in other words, people paying the same premium but absorbing much different levels of service. I would argue that it is more efficient from everybody's point of view to have the cross-subsidies through the tax system, which in a sense is a similar kind of cross-subsidy, but instead of looking for certain groups and trying to keep the premium and risk in line, you do it through the entire population and have the tax system being your method of cross-subsidy.

Either way, you've got to have a cross-subsidy. I just feel that once you start trying to make insurers or employers carry risks that are higher than the premium or the amount they are normally prepared to pay for an employee in terms of compensation, once you start to try to do that, you are going to get cost shifting and discrimination one way or the other.

If you, however, allow the market to function and say that some people indeed will face very high premiums, they will get a very high offsetting credit to that, and similarly, some people will gravitate to low-cost plans and won't get much of a tax break, that in my view is a much more efficient method of cross-subsidy and avoids what I see as the intractable problem of cost-shifting and risk selection based on artificial premiums.

The CHAIRMAN. Mr. Butler, do you know of any political leader in any industrialized Nation in the world who wants to abandon their national health care program and go to a private individual consumer program?

Mr. BUTLER. Well, I do know of places which have——

The CHAIRMAN. Just any political leader or any political party?

Mr. BUTLER. That wants to go toward which kind of system?

The CHAIRMAN. To abandon universal coverage.

Mr. BUTLER. I support universal coverage. There is nobody that I am aware of who wants to abandon universal coverage, and I don't support that either. But there are certainly cases—Britain is an example—of trying to introduce more effective markets within the system. The Canadians have also been trying to do the same thing.

So the notion of recognizing that there is a perverse problem here of consumers facing no cost and therefore having some kind of rationing, people across the world are looking at ways of trying to introduce some kind of incentive system, and I agree with that.

The CHAIRMAN. But not effectively abandoning or throwing over their basic system.

Mr. BUTLER. Of universality, no—and I don't support that either.

The CHAIRMAN. Let me ask Professor Thorpe what you think of the argument that everyone will dump into the public plan, and costs will rise high, too. Could you explain the logic of the "pay or play"?

Mr. THORPE. Again, the design of the "pay or play" does a couple of things that I think earlier versions of the bill were criticized for. First, it treats part-time and full-time workers exactly the same, so there are no economic disincentives there. Second, it provides portability of coverage between the public and private plan. Third—and this goes directly to your point—the whole reason for having a payroll tax approach as a financing scheme was based on a view of fairness. That is, the cost of providing insurance in low-wage firms is going to be less under a payroll tax than it is under another type of tax.

When we have done the estimates looking at a 7 percent or effectively a 9 percent total payroll tax, it turns out that the number of people with private insurance rises. That is, there are a number of employers who are uninsured firms who are high-wage firms that go out and purchase private health insurance. It is just economically more advantageous for them to do that.

The payroll tax is really focused on blunting the economic burden to low-wage firms, many of which would indeed purchase public insurance, but many employers would decide that it is more economically advantageous to purchase private insurance. In versions of the estimate that I have seen, you have private insurance rising under this proposal.

So I think the issue of dumping at least in the first year out is somewhat overstated. Over time the issue will be whether or not the rate of increase in cost deviates dramatically from payroll. If it is growing at 5 or 10 percentage points faster than payroll, clearly there is some interest in looking at a public plan, but at least initially the numbers that we have looked at suggest that with a 7 or 8 percent payroll tax you do have private insurance rising, and you do have some low-wage firms purchasing public insurance.

The CHAIRMAN. OK. Thank you all very much. This has been enormously interesting.

Our second panel consists of Gerry Adams, professor of economics, University of Pennsylvania, and John Sheils, vice president of Lewin/ICF.

Gerry is a distinguished economist who has testified before this committee several times in the past, and John is a well-known policy analyst who has been deeply involved in producing estimates and analyses for the Pepper Commission and a number of other major policy projects.

We'll start with Professor Adams, but I will recess until Senator Wellstone returns, which will be momentarily, and then we'll get started on the testimony.

Senator JEFFORDS. Mr. Chairman, I will have to leave as well. I assume we'll have the right to ask questions in writing of the panelists.

The CHAIRMAN. Yes. We'll recess briefly.

[Recess.]

Senator WELLSTONE [presiding]. The committee will come to order. I understand introductions have already taken place, so we'll start out with Professor Adams. Thank you for being here.

STATEMENTS OF F. GERARD ADAMS, PROFESSOR OF ECONOMICS, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA; AND JOHN SHEILS, VICE PRESIDENT, LEWIN/ICF, WASHINGTON, DC

Mr. ADAMS. Thank you, Senator. I'd like to thank the committee for allowing me to speak on this important topic.

In the interest of time, I will try to shorten my statement.

The availability of health care to all citizens, regardless of their economic status, is fundamental. A Nation is judged on how well it takes care of its sick, young and old, employed and unemployed. It is unthinkable that at this time of enormously high medical costs, millions of Americans have no health care insurance coverage or are inadequately covered. They cannot afford, and frequently do not get, required medical care.

As we know, it is the purpose of S. 1227, the HealthAmerica bill, to extend health care coverage to all Americans, to provide a means to finance this extension and to keep down its costs as much as possible.

These objectives are so basic that I will not question them. It is my purpose, rather, to ask whether such a plan can be accommodated without imposing large burdens on the economy in terms of inflation, lost employment and output.

While the aims of the plan are at the level of individuals, to provide coverage for people who do not have such coverage, an important consideration is its impact on the economy as a whole. Ultimately, this impact determines whether or not we can afford such a program.

What are likely to be the effects of HealthAmerica on the micro level, that is to say, on the level of individual workers and firms? I will not elaborate the importance of such a program in protecting the health of individuals who are now inadequately covered. It is not only a matter of providing for the actual care for the sick. It is

also a matter of security and respect. No longer will uninsured people have to fear what may happen in case of serious medical problems, that they may not receive care, or that they will need to go on public assistance.

On the other hand, we must be frank to recognize that the gains of this program come at some cost to the employer and to the individual receiving coverage. Many employers are already paying health care coverage costs so that for them there will be little or no change. But certain employers will bear cost increases of 7, 8 percent of base payrolls, either to cover the cost of private health insurance or of the payroll levy.

It is understandable that small employers are particularly concerned about this additional cost burden. But more important, in evaluating the impact, we must recognize that all employers will ultimately be responsible for the same costs or payroll tax. The cost will be spread fairly to all employers regardless of size. It is probable that such a cost increase attributable to new medical programs or the payroll level will be widely passed on in the price of the product or the service sold. It should not in general impair the competitive position of one firm relative to others.

A major micro level concern has been that increased labor costs will cause unemployment, causing employers to hire fewer workers. Again, we must recognize frankly that an increase in labor costs may cause some employers to consider alternative methods of production. There may be some job losses. The issue here is not one of principle, but one of dimension.

Empirical studies suggest that the increase in labor cost associated with health care is not likely to have severe unemployment effects. Many of the firms that will incur additional costs for health coverage or the payroll levy are firms in low-technology or service industries. They are not likely in large numbers to lay off workers. On the contrary they may find that healthier, happier workers represent a more stable labor force.

We must not forget, as some studies do, that the HealthAmerica plan also creates jobs, directly in the health care field and indirectly through added expenditure, causing modest economic stimulus.

Now, I turn next to what we as economists call the macroeconomic effects. To evaluate the macroeconomic impacts of the HealthAmerica plan, we have introduced assumptions about the plan into the forecasts of the Wharton econometric model. We have experimented with two versions of the model and with alternative formulations of the assumptions to obtain a broad idea of what the plan would mean on the level of the entire economy. A typical result of these calculations is shown in Table 1 of my statement.

I want to stress that these figures should be seen as broad orders of magnitude, not as precise results. Their implications are clear, however. The HealthAmerica plan can be accommodated in the economy with quite small relative effects on important variables measuring economic performance, GNP, employment and inflation.

The impact of the program builds up gradually as a larger number of workers and unemployed people are covered. By the fifth year, the effect on the level of the CPI and on the GNP deflator is approximately ½ percent, an increase in the inflation rate over the 5-year period of 0.1 percent annually. Unit labor costs at

that point are a little over one percent higher than they would otherwise be.

In this particular simulation, there is a reduction in the level of the GNP of approximately ½ percent and associated with that, a reduction of employment of approximately 0.2 percent—somewhere around 200,000 workers, with an increase in the unemployment rate of 0.2 percent.

These are relatively small numbers, but I want to stress the fact that they are the maximum which I obtained with a variety of alternative simulations. We did a number of simulations, and the precise result that you get depends entirely on the assumptions that you make with respect to the increase in spending associated with the HealthAmerica plan. If I throw in another $10–$15 million a year of expenditures, even though covered with taxes, they will easily wipe out any negative employment effect which has been observed here.

It has been noted to me that in this particular calculation, we show a reduction in employment of 200,000 people, whereas a few years ago when I testified on the minimum wage plan, our calculations suggested an employment impact of 100,000. And by the way, I think, looking back on the history of that minimum wage increase, we were well within the appropriate order of magnitude.

The CHAIRMAN. I want you to keep your eye on it, because we're going to get another chance next year to raise it again.

Mr. ADAMS. Will do.

I want to stress here that 100,000 or 200,000 are orders of magnitude. These are very small numbers out of the total labor force, vast in excess of 100 million. In this particular instance, what I'm really saying with the model is that the employment effect is likely to be small. I don't differ even with Karen Davis' 50,000, again an order of magnitude. The precise numbers depend very much on what the expenditures are that are associated with the plan, what other policies are that are going on in the economy at the same time. We are talking about small changes in employment.

How can we interpret these macro impacts? First, it is apparent, as I have said, that the impact of balanced changes, increases in payroll taxes offset by increased expenditures on health care, are small in the aggregate. We see no evidence of large employment effects that some observers have feared.

Second, there is a small inflationary impact, but it is very small indeed. It reflects the fact that cost increases will be largely passed on in the form of slightly higher prices. Even small businesses will generally be able to pass along these cost increases since all business will be providing the same basic benefits or paying the payroll tax. The cost containment provisions of the act are likely to reduce even this small impact. And I stress the fact that the cost containment provisions are a very important thing. Generally, businessmen need not fear that the health care cost increases will come out of their bottom line revenues.

Third, the simulations we have carried out suggest that with some increases in real health care spending, even if the costs of additional health care are offset by taxes, there may be stimulating effects on the economy. Indeed, this stimulus could easily offset the small unemployment effects that we have observed. The calcula-

tions suggest that we can well afford the extension of health care benefits to those presently uncovered, as proposed in the HealthAmerica plan. Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Adams follows:]

PREPARED STATEMENT OF MR. ADAMS

The availability of health care to all citizens, regardless of their economic status, is fundamental. A nation is judged on how well it takes care of its sick—young and old, employed and unemployed. It is unthinkable that, in this time of enormously high medical costs, millions of Americans have no health care insurance coverage or are inadequately covered. They cannot afford, and frequently do not get, required medical care. It is the purpose of S. 1227, the HealthAmerica bill, to extend health care coverage to all Americans, to provide a means to finance this extension, and to keep down its costs as much as possible. These objectives are so basic that I will not question them. It is my purpose rather to ask whether such a plan can be accommodated without imposing large burdens on the economy in terms of inflation or lost employment and output. While the aims of the plan are at the micro level, to provide coverage for people who do not have such coverage, an important consideration is its impact on the economy as a whole, what economists term its macro effects. Ultimately these impacts determine whether we can afford the program.

CAN WE AFFORD HEALTHAMERICA?

The United States economy is in the recovery phase from its recent recession. Economic activity is now expected to resume growth, a little below its normal rate of 3 percent per year, a pace that represents continued progress, though it is somewhat slower than most of us would like to see. Current forecasts do not foresee a return to high demand pressure inflation nor a situation where our nation's ability to meet essential needs like health care is constrained by insufficient resources.

Calculations with various versions of the Wharton Econometric Model of the United States economy [1] suggest that the HealthAmerica plan can be phased in with little, if any, negative impact on employment and output, and with only minimal temporary effect on the overall rate of inflation. Indeed, the cost containment measures may work to offset this effect on prices. The calculations, discussed in more detail below, indicate that we can afford to allocate some of our nation's income flow to better coverage of health care costs. Indeed, we can ill afford not to do so!

DIMENSIONS OF THE HEALTHAMERICA PLAN

The HealthAmerica program aims to extend health insurance coverage to the entire U.S. population over an adjustment period of five years. Employers will be encouraged to provide or extend private coverage. It is hoped that many additional workers will be covered in this way. The plan provides, in addition, that AmeriCare coverage will be extended to children and pregnant women, to workers whose firms do not provide adequate coverage, and ultimately to the unemployed.

Employers will have a choice to participate in private coverage for their workers meeting national standards or to pay a payroll tax that will go to provide coverage under AmeriCare.

Many large employers already offer adequate health insurance coverage and will continue to provide it. Most of them recognize health costs as part of their labor expense so that only a minority will incur additional costs of private coverage or pay the payroll tax. As the program is extended to smaller employers (50 to 99 employees) in the fourth year and to all employers including the smallest businesses by year five, the proportion who will have to increase their spending for medical care insurance or make payroll tax payments become much larger, because a much smaller fraction of small employers are now providing such coverage. Over the entire economy, the out of pocket cost to employers for financing their part of the program is not large, we estimate a rise of less than 0.5 percent annually of wage

[1] I would like to thank Brian Morrigan of the WEFA Group and Gene Muang of the University of Pennsylvania for assistance with these calculations.

costs, above what otherwise would have been expended per year over the next five years.

It is likely that private sector and public sector spending for health care will increase. The magnitude of this increase is uncertain, however. On one hand, an increase would show that the plan is reaching individuals who have until now been denied proper health care—employed people with inadequate coverage, uncovered children, and the unemployed. That, after all, is a primary objective. On the other hand, the cost containment measures of the bill should hold down costs to all participants, private and public, and the provision of AmeriCare may reduce the burden of "unpaid-for" medical care which now often fails on private health coverage providers. The cost containment provisions of the bill are important since the rise of health care costs, in part due to failure of market mechanisms, has been a source of inflationary pressures even when the economy has been in recession.

We estimate that health coverage costs will exceed what is collected by the payroll levy by perhaps 25 percent, but we have also considered the alternate possibility that more substantial additional costs will be incurred, the framers of this bill have recognized the need to avoid budget deficits. Provision will be made to cover the extra costs incurred by the HealthAmerica plan beyond what is provided by the payroll levy by other tax changes or expenditure reductions. This will minimize the economic effects of any additional spending.

Micro Effects

What are likely to be the impacts of HealthAmerica on the micro level, the level of individual firms and workers?

I will not elaborate the importance of such a program in protecting the health of individuals who are now inadequately covered. It is not only a matter of providing the actual care to the sick. It is also a matter of security and respect. No longer will people have to fear what may happen in case of serious medical problems; that they may not receive care or that they will need to seek public assistance.

We must be frank to recognize that there will be costs for the employer and for the individual receiving coverage (80 percent to be paid by the employer and 20 percent by the covered individual except for poor people). Many employers are already paying health care coverage costs, so that for them there will be little or no change. But, certain employers will bear cost increases, now estimated to be between 7 and 8 percent of base payrolls, either to cover the cost of private health insurance or of the payroll levy. It is understandable that small employers are particularly concerned about this additional cost burden. The bill provides special provisions for small employers with financial problems. But more important in evaluating the impact, we must recognize that all employers will ultimately be responsible for the same costs or payroll tax. The cost will be spread fairly to all employers regardless of size. It is probable that a cost increase attributable to new medical programs or the payroll levy, will be widely passed on in the price of the product or service sold.[2] It should not, in general, impair the competitive position of one firm relative to others.

A second micro level concern has been that increased labor costs will cause unemployment, causing employers to hire fewer workers. Again, we must recognize frankly that an increase in labor costs may cause some employers to consider alternative methods of production. There may be some job losses. The issue here is not one of principle, but of dimension. Empirical studies suggest that the increase in labor cost associated with health care is not likely to have severe unemployment effects. Many of the firms that will incur additional costs for health coverage or the payroll levy are the firms in low technology or service industries. They are not likely in large numbers to lay off workers. On the contrary they may find that healthier, happier workers represent a more stable better labor force.

We must not forget, as some studies do, that the HealthAmerica plan also creates jobs directly in the health care field. If there are added expenditures the plan provides modest economic stimulus. This means that job losses are largely offset by the economic stimulus associated with the medical care plan. In the aggregate, the number of jobs available will not change significantly.

Macro Effects

To evaluate the macroeconomic impacts of the HealthAmerica plan, we have introduced assumptions about the plan into the base forecasts of the Wharton Econo-

[2] There is little empirical evidence that it will produce an offsetting reduction in wages.

metric Model. The specifics of the plan are not easy to introduce into the model system, particularly since some of this impacts on medical care costs and expenses incurred are only imperfectly known. Consequently, we have experimented with two versions of the model and with alternative formulations of the assumptions to obtain a broad idea of what the plan would mean on the level of the entire economy.[3] The typical results of these calculations are shown in Table 1.

Table 1—Macroeconomic Effects of S. 1227

(percent differences from base, except where indicated)

	92	93	94	95	96	97	98	99	2000
GNP real	-0.03	-0.14	-0.25	-0.37	-0.49	-0.58	-0.058	-0.59	-0.62
CPI	0.07	0.19	0.32	0.45	0.58	0.62	0.82	0.81	0.60
GNP deflator	0.07	0.18	0.28	0.39	0.51	0.53	0.52	0.52	0.58
Unit Labor Cost	0.25	0.53	0.79	1.05	1.30	1.25	1.22	1.20	1.19
Employment	-0.01	-0.07	-0.13	-0.18	-0.21	-0.23	-0.17	-0.11	-0.05
Unemployment Rate *	0	0.1	0.1	0.2	0.2	0.2	0.2	0.1	0

* absolute difference

These figures should be seen as broad orders of magnitude, not as precise results. Their implications are quite clear, however. The HealthAmerica plan can be accommodated in the economy with quite small relative effects on important variables measuring economic performance GNP, employment and inflation.

During the early years of the plan, its impact on the entire economy is likely to be quite small. We note that many larger businesses already support health insurance plans and that only a small fraction will need to provide coverage or pay the payroll levy. Coverage of children and pregnant mothers will impose costs on the system. Our model computations suggest that at the beginning the impact on employment and economic activity will be very small.

The impact of the program builds up gradually as a larger number of workers are covered and as it is extended to children, pregnant mothers, and the unemployed. By the fifth year, the effect on the level of the CPI and on the CNP deflator is approximately 1/2 percent, an increase in the inflation rate of 0.1 percent annually. Unit labor costs at that point are a little over 1 percent higher than they would otherwise be. There is, in this case, a reduction of employment of approximately 0.2 percent, somewhere around 200 thousand workers with an increase in the unemployment rate of 0.2 percent. Over time, these effects appear to stabilize.

We note however, that alternate simulations which assume a somewhat larger expenditure impact (offset by increased tax revenues) show somewhat more favorable impacts. The macroeconomic effect of additional spending on health care, stimulates the economy so that GNP remains positive and so that the employment impacts are largely offset.

How can one interpret these macro impacts? First, it is apparent that the impact of balanced changes, increases in payroll taxes offset by increased expenditures on health care are small. We see no evidence of the large employment effects some observers fear. These may be a result of not considering all sides of the market as we do on our macro model simulations.

Secondly, there is a small inflationary impact, but it is very small indeed. It reflects the fact that the cost increases will be largely passed on in the form of slightly higher prices. Even small businesses will generally be able to pass along these cost increases since all businesses will be providing the same basic benefits or paying the payroll tax. The cost containment provisions of the act are likely to reduce even this small impact. Generally, businessmen need not fear that the health care cost increases will come out of their bottom line revenues.

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[3] The phasing in of the program is not smooth either on the payroll levy or the services side. The inclusion of large employers comes the first year, but smaller firms (50–99 employees) are not mandatorily included until year 4 and small firms not until year five. It is likely that the extension of health coverage to the presently uninsured will not happen abruptly. The phasing in of children and pregnant women occurs in the first year, but coverage for the unemployed is not provided until year five. This also means that the impacts will not be smooth. Rather than focus on these steps we present results over the average of the five years since economic adjustments are likely to be gradual.

Thirdly, the simulations we have carried out suggest that within reasonable limits, even if the costs of additional health care are offset by taxes, there will be some stimulating effect on the economy. Indeed, this stimulus could easily offset the small unemployment effects observed.

The calculations suggest that we can well afford the extension of health benefits to those presently uncovered, as proposed in the HealthAmerica plan.

The CHAIRMAN. Mr. Sheils.

Mr. SHEILS. Good afternoon. I was asked to estimate the impact of the cost containment provisions of the HealthAmerica Act, and I am delighted to have been asked to present the results here this afternoon.

The 1980's were a paradox of dramatic increases in national health spending and, for many Americans, diminished access to care. The percentage of our gross national product devoted to health care increased from 9.5 percent in 1980 to over 12 percent by 1990. Despite this massive infusion of national wealth into the health care sector, the number of uninsured persons in this country increased from 24 million in 1980 to 33 million in 1990—an increase of 9 million persons.

The relationship between cost and access is an important one. As costs go up, quite simply, fewer and fewer employers and households can afford it. Effective cost containment strategies may prove necessary in maintaining even the existing level of insurance coverage, let alone any efforts to expand coverage.

What are the consequences of doing nothing? In 1990, we spent about $606 billion on health care. It is currently projected that per capita health spending will grow at an annual rate of about 8.6 percent. That is a little more than twice the rate of inflation. By the year 2000, health spending will rise to about $960 billion—$960 billion in inflation-adjusted dollars. This would be like going home tonight, opening your mail, and finding that the cost of health insurance had gone up by 60 percent; then, coming in to work tomorrow morning and trying to find a way to fund a 60 percent increase in the cost of Federal health programs.

Even relatively modest efforts to contain the growth in health care costs can have a substantial impact in the long run. For example, if we were to somehow wrestle down the rate of growth from 8.6 percent to just 7.6 percent, just a one percent reduction, by the year 2000 we would spend about $85 billion less for health care than is currently projected.

The HealthAmerica Act introduces several cost containment initiatives. The first would reduce unnecessary and ineffective utilization through expanded development and promulgation of medical practice guidelines, creating a technology assessment program, and expanding the use of managed care among small employer groups.

Second, it promotes competition by preempting State-mandated benefits and requiring publication of provider rates.

Third, it would reduce the cost of administering insurance through small group insurance market reform and the creation of an insurance consortium to assist in the administration of claims for small groups.

Fourth, it establishes a Health Expenditure Board which would set national health spending targets and work with providers to es-

tablish provider reimbursement rates consistent with these spending targets.

We estimate that over the 1992–1996 period, a 5-year period, these provisions together will save about $83 billion in health spending. These savings will in part be offset by increases in utilization as coverage is extended to the uninsured population.

Over the 1992–1996 period, we estimate an increase in utilization for newly-insured persons of about $37 billion. So the net savings of the HealthAmerica Act would be about $46 billion over the 5-year period ending in 1996.

You might open to page 21 of my testimony where there is a graphic that I think will help. The last page of my presentation shows the savings associated with the various cost containment initiatives of the bill.

Total savings under the cost containment initiatives of this bill would be about $83 billion over the 5-year period. Just over half of those savings—just over half—would be associated with elimination or efforts to eliminate unnecessary or ineffective care through medical practice guidelines, technology assessment program, and expanded managed care.

This is very important because here is an effort to control cost which basically does it by improving the quality of care. Studies have shown that for some procedures, up to 30 percent of the care provided was unnecessary, and in fact in some cases proved to be harmful to the patient.

Practice guidelines and managed care is an attempt to cut costs by moving individuals to more effective and beneficial modes of treatment. Administrative savings under the program would account for about $16 billion in savings, or about 19 percent of the total savings.

Efforts to promote competition, which include preempting State mandates, would save another $9.3 billion.

Finally, we estimated here quite conservatively that the Health Expenditures Board would save about $15 billion over that period.

In doing this study we chose to be conservative in estimating the impact of the Health Expenditures Board. In fact we were conservative in estimating all of these impacts. In fact, studies of State hospital rate-setting programs indicate that these programs have slowed the rate of growth in hospital by anywhere between 15 and 30 percent, depending upon the study you look at.

To illustrate the potential impact of the Health Expenditures Board on spending, if the board were to be successful in slowing the rate of growth in health spending from 8.6 percent to 7.6 percent, a one percent reduction, the savings over the 5-year period we are looking at would total about $90 billion.

This concludes my prepared remarks. I just want to say that it is an honor to have been asked to address the committee.

[The prepared statement of Mr. Sheils (with attachments) follows:]

Prepared Statement of Mr. Sheils

My name is John Sheils. I am a vice president with Lewin/ICF, a Washington-based consulting firm, specializing in health care financing issues. I have performed financial analyses of various health care reform proposals for several public and pri-

vate organizations including: the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission); the Congressional Research Service; the Advisory Council on Social Security; several state commissions; the American Hospital Association; and other private organizations. I was asked to evaluate the potential impact of several cost containment initiatives included in S. 1227. I am honored to have been asked to summarize my findings for the committee this morning.

The potential impact of changes in health care delivery systems and administrative procedures are very difficult to estimate. The estimates presented here are based upon the best available data on the potential savings associated with various cost containment models. Still, data on the likely impact of these provisions is often unavailable or inconclusive. Therefore, these estimates should be considered illustrative of potential impacts rather than definitive projections of cost savings.

In developing these estimates we assumed that these programs are implemented in 1992. Our estimates reflect assumed lags in the implementation of cost containment initiatives. The estimated impact of these initiatives on national health spending are presented for 1992 through 1996. Five year totals are also provided. The methodology used to develop these estimates is discussed below. I begin by summarizing several issues in cost containment.

A. HEALTH CARE COSTS AND ACCESS

The 1980's were a paradox of dramatic increases in health spending and diminished access to care. Health spending as a percentage of gross national product grew from 9.1 percent in 1980 to about 12 percent by 1990 (Figure 1). Despite the dramatic growth in the share of our national wealth devoted to health care, the number of persons without insurance increased from 24.5 million in 1980 to over 33.3 million by 1990, an increase of 9 million. Rising costs have made health insurance less affordable, which has contributed to reductions in insurance coverage, increased uncompensated care costs, and increased the strain on state and local indigent care programs. Cost containment will be an essential element of any program to expand insurance coverage and could prove vital in maintaining even the existing level of access.

The importance of containing the growth in health spending is evident in current projections of health spending for the next decade. The Health Care Financing Administration (HCFA) projects that per capita spending on health care will increase at an annual rate of 8.6 percent per year through 2000. This is about twice the projected rate of inflation. In 1990 health care costs were about $605.9 billion (Figure 2). By 2000, health spending is projected to grow to $960 billion (in 1990 dollars). This is a real increase (inflation adjusted) in health spending of 60 percent.

A seemingly small change in the annual rate of growth in health spending would have a dramatic impact on health care costs in future years. For example, assume that we implement a cost containment strategy that reduces the rate of growth in health spending from the projected annual rate of 8.6 percent to 7.6 percent. By 2000, health care spending would be approximately $85 billion (in 1990 dollars) lower than currently projected (Figure 2). If the annual rate of growth were slowed to 6.6 percent, annual health spending in 2000 would be about $162 billion (in 1990 dollars) less than projected. These estimates suggest that even modest changes in health practice can have sizable long-term benefits.

S. 1227 includes a number of cost containment initiatives which could potentially reduce the rate of growth in health spending. These initiatives include efforts to improve the administrative efficiency of the health care financing system, promote competition, permit innovation in developing lowcost insurance products, and creates a mechanism for controlling the growth in provider reimbursement rates.

The proposal would also promote cost effective medicine by encouraging managed care and developing and promulgating medical practice guidelines. Managed care and medical practice guidelines could potentially reduce costs while improving quality by eliminating excessive and unnecessary utilization (see Figure 3). These efforts to change medical practice will also promote needed preventive care thus avoiding preventable hospitalizations in future years. These efforts to change medical practice patters are designed to produce long-run savings by maximizing the use of cost effective medical practices.

The methodologies used to estimate the impact of the S. 1227 cost containment initiatives are discussed below.

B. NATIONAL HEALTH SPENDING: CURRENT PROJECTIONS

Estimates of national health spending under current policy in future years (see line B of Figure 4) are based upon health spending projections developed by the Health Care Financing Administration (HCFA). HCFA projects that per-capita

health spending will grow by about 8.6 percent per year through 2000 which is about double the projected rate of inflation.[1]

C. UTILIZATION INCREASE FOR PREVIOUSLY UNINSURED PERSONS

Utilization of health services by previously uninsured persons is expected to increase as these individuals become insured (either through employer coverage or the public plan). Utilization of health services by previously uninsured persons is assumed to adjust to the levels reported by insured persons with similar age, sex, income and health status characteristics. The total increase in national health spending for newly insured persons would be about $14.7 billion if the program were fully implemented in 1992 which represents an increase in national health spending of about two percent. However the increase in insurance coverage and the resulting increase in utilization under S. 1227 would be phased-in between 1993 and 1997 as follows:

—Beginning in 1993, the employer coverage provisions of the Bill would apply to only firms with 100 or more workers. Coverage of pregnant women and children under the public plan would also begin in this year.
—In 1996, the employer coverage provisions will be extended to all firms with 25 or more employees.
—The employer coverage provisions will apply to all firms beginning in 1997. Coverage of non-working adults under the public plan will also begin in this year.

This phased expansion of coverage is reflected in the utilization estimates shown in Figure 4.

D. ADMINISTRATIVE SAVINGS UNDER THE PUBLIC PLAN

We estimate that under the provider-or-contribute model about 15 million workers who are currently insured under private employer health plans will be shifted to the public plan. These include workers and dependents in firms that now offer insurance who find it less costly to pay the tax than offer insurance.

This will reduce administrative costs by shifting individuals from small employer plans where administrative costs average about 28 percent of incurred claims to the public plan where administrative costs for small groups are estimated to be only about 15 percent of claims.[2] Total savings in administrative costs are estimated to be about $800 million in 1992.

The legislation also calls for insurance market reforms which will limit underwriting practices resulting in reduced insurer administrative costs. Estimated savings resulting from these changes are discussed below.

E. REDUCE UNNECESSARY AND INEFFECTIVE CARE

The proposal includes two provisions designed to reduce costs associated with unnecessary and ineffective treatments. These include:

Expanded Development of Medical Practice Guidelines

The proposal calls for expanded use of medical practice guidelines in both public and private sector programs. A growing body of research exists on Medical practice guidelines which would be implemented under the program.

Medicare—It is estimated that research performed to date on 20 major procedures has produced practice guidelines which if fully implemented would result in savings to Medicare of up to $2.5 billion (in 1991 dollars).[3] We assume that the savings from these practice guidelines will phase-in over a three year period beginning in 1992. Medicare savings from ongoing medical guidelines research is assumed to increase by $500 million per year (in 1991 dollars) starting in 1995.

Private Sector—It is estimated that existing practice guidelines data could reduce premium costs in employer based plans by as much as three percent.[4] We assume that these savings will occur primarily among persons not already enrolled in plans with selective contracting arrangements. Savings are assumed to be phased-in over a three year period. Potential savings are assumed to increase by 0.25 percent of premiums beginning in 1995 as new research becomes available.

Technology Assessment

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[1] Health Care Financing Review/Summer 1987/Volume 8, Number 4.
[2] Estimates of administrative loads under various public and private insurance models are based upon estimates provided by the Congressional Research Service.
[3] Unpublished data provided by Karen Davis of Johns Hopkins university.
[4] Presentation by Mark Chasim to the Florida Task Force on Private Sector Health Care Responsibility.

A program would be initiated to determine the appropriate use and reimbursement levels for new technologies. For illustrative purposes we have assumed that this program induces a 12 month lag in the adoption of new technologies. We estimated the impact of this assumption by imposing a 12 month lag in the portion of health care inflation attributed to service intensity (it is estimated that about 25 percent of health care inflation is attributed to a growth in service intensity).[5]

F. PROMOTE COMPETITION

Provider competition would be encouraged by requiring providers to publish their rates. These data would encourage providers to be more competitive and would facilitate selective contracting. This competitive model is used in California and is estimated to have reduced the annual rate of growth in hospital costs by about 10 percent.[6]

We assume that under this provision, the growth in hospital spending will be slowed by 10 percent per year. Savings are assumed to occur only in states that do not now have hospital rate setting systems or a comparable competitive model (these include California, New York, Maryland, New Jersey and Massachusetts). Savings are assumed to be phased-in over a three year period.

G. ENCOURAGE MANAGED CARE

The Legislation includes several initiatives to expand managed care. These include:

Pre-empt State Legislative Barriers

The proposed legislation would pre-empt all barriers to selective contracting, utilization review and other managed care practices. We assume that this will result in a 10 percent increase in the number of workers in HMO's.[7] We also assume that HMO's will reduce health spending for newly covered groups by about 10 percent. These savings are assumed to be phased-in over the course of three years.

Small Business Access to Managed Care Plans

Carriers would be required to offer managed care options to all small groups. We assume that HMO enrollment among firms with under 25 employees would rise to the level observed in large firms. Managed care plans are assumed to reduce costs by 10 percent for workers who enroll. These savings are assumed to be phased-in over the course of three years.

Provide Managed Care In The Public Program

HMO's will be made available to workers covered under the public plan. We assume that the percentage of workers enrolling in these plans will be comparable to the percentage of privately insured workers covered under HMO's. Savings are estimated to be 10 percent for persons who become covered under these plans. Savings are assumed to be phased-in over a three year period.

H. PRE-EMPT STATE MANDATED BENEFITS

The legislation establishes a federal minimum benefits standard which pre-empts state mandated benefits. State mandates include: Newborn care (46 states), psychiatric care (37 states), chiropractors (35 states), Dental care (27 states) and other services. State mandated benefits have been estimated to add about 15 percent to the cost of health insurance.[8]

Of the benefits required by states, the federal standard would require coverage of psychiatric and newborn care which accounts for about 53 percent of the cost of state mandated benefits. Thus 47 percent of the cost attributed to state mandates (about seven percent of premiums) is potentially eliminated. These savings do not apply to self-insured plans because they are already exempt from state benefit mandates under ERISA.

We assume that half of all employers who now purchase insurance will eliminate coverage for state mandated benefits that are not required under the federal benefits standard (i.e., some may wish to retain dental coverage etc.). Utilization of these services for persons in plans that discontinue these benefits is assumed to decline by about 20 percent.[9]

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[5] Based upon Lewin/ICF analysis of HCFA data on the components of health price inflation.

[6] James Robinson and Harold Luft, "Competition, Regulation, and Hospital Costs, 1982 to 1986", JAMA, November 11, 1988, Volume 260, No. 18.

[7] About 15 percent of all workers are in a Hearth Maintenance Organization. GHAA's National Director of HMO's, 1990 edition.

[8] Jon Gabel and Gail Jensen, "the Price of Mandated Benefits", Inquiry 26:419–431 (Winter 1989).

[9] We assume that a one percent change in the price of health services to the individual is associated with a 0.2 percent reduction in utilization of these services.

I. ADMINISTRATIVE COSTS

The legislation includes several initiatives to reduce administrative costs in private insurance. These include:

Insurance Consortia

An insurance consortia is established in each state to consolidate administrative procedures for insurers with small market shares. It will also facilitate the system wide development of cost saving innovations such as "smart" cards for electronic claims transmittal.

Industry analysts estimate that electronic claims transmittal will save about 50 cents per claim for a maximum potential savings of $400 million per year. For illustrative purposes, we assume that under the consortia's leadership, all insurers will convert to the electronic claims transmittal systems over a five year period.

Establish Quality Improvement Agencies

Quality improvement agencies would be created in each state to work with providers to develop a program of continuous quality improvement and implementation of cost effective methods of delivering care. The agency would periodically certify providers as practicing in a cost effective manner thus exempting them from utilization review for a period of up to a year. This will avoid duplicative provider review and focus limited resources on providers who appear to be inclined to over-prescribe.

We assume that the primary impact of this provision will be to improve the effectiveness of utilization review. For illustrative purposes we assume that this provision improves the cost saving potential of managed care plans by 10 percent.[10] These savings are assumed to be phased-in over a period of three years.

Small Business Insurance Reform

The legislation would substantially limit insurer underwriting practices and eliminate pre-existing condition limitations. This will reduce insurer administrative costs associated with approving a policy and reduce claims processing costs by eliminating the need to cross-reference claims with pre-existing condition limitations.

Administrative costs for small employers would be reduced from their current level of about 28 percent of claims to about 21 percent of claims. We developed this estimate by assuming that the portion of administrative costs in small groups attributed to general administration and claims processing costs would be reduced to the levels observed in larger firm size groups (i.e., firms with 25–50 employees).[11] These savings are assumed to be reflected in premiums immediately upon implementation of the program.

J. THE FEDERAL HEALTH EXPENDITURES BOARD

S. 1227 creates a Federal Health Expenditures Board which will set national expenditure targets. The Board will then attempt to negotiate rates with providers which are consistent with these spending targets. If the Board is unsuccessful in negotiating these rates, individual health insurance plans will be permitted to adopt these rates if they chose.

The impact of this provision is impossible to predict because we have no way of predicting the expenditure targets the Board will select and we can not anticipate how effective the board will be in negotiating rates. For illustrative purposes, we assume that the program will be roughly as effective as past voluntary expenditure target programs have been in slowing the growth in health spending.

Voluntary targets for hospital expenditures were attempted in 1978 and 1979 as an alternative to the mandatory targets that had been proposed in Congress. Hospitals achieved their targets in 1978 which slowing the rate of growth in hospital spending by about 12 percent (i.e., the percentage growth in hospital revenues in 1978 was about 12 percent less than cost trends would have indicated). Hospitals failed to meet their goal in 1979 possibly due to reduced Congressional interest in mandatory budget targets.

Based upon this experience, we assume that voluntary targets would reduce the rate of growth in hospital costs by 12 percent. However, we also assume that some portion of these savings will overlap with savings achieved through efforts to increase provider competition (estimated to reduce the growth in hospital spending by about six percent). Thus, the net impact of the voluntary targets would be an additional reduction in the rate of growth in hospital spending of about six percent.

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[10] We assume that HMO's reduce costs by about 10 percent and PPO's reduce costs by about five percent. We assumed that the reduction in costs under these arrangements is increased by five percent.

[11] Based upon administrative data developed by Hay/Huggins Inc. for the Congressional Research Service (CRS).

For illustrative purposes, we also assumed that the annual growth in spending for physicians' services will be reduced by 12 percent under a voluntary expenditure targets. Evidence of the potential success of voluntary cost control programs will soon be available under the Medicare volume performance standards programs which incorporates voluntary targets as an initial step in containing the growth in Medicare Part B expenditures.

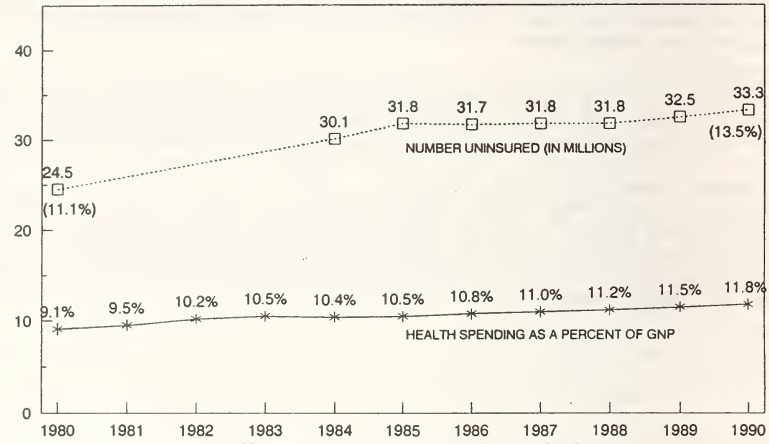
K. SUMMARY

Total savings due to the cost containment initiatives under S. 1227 will be about $83.17 billion over the 1992–1996 period. These savings will be partly offset by increases in utilization among newly insured persons under the Bill of about $37.4 billion over this five-year period. Thus S. 1227 will result in net savings over the 1992–1996 period of about $45.8 billion (Figure 5).

Over half of the savings under S. 1227 (Figure 6) will be attributed to efforts to change medical practice (medical practice parameters and managed care). The Health Expenditures Board would account for about 18.6 percent of projected savings ($15.5 billion). About 19.6 percent of the savings would be attributed to administrative efficiencies under S. 1227.

FIGURE 1

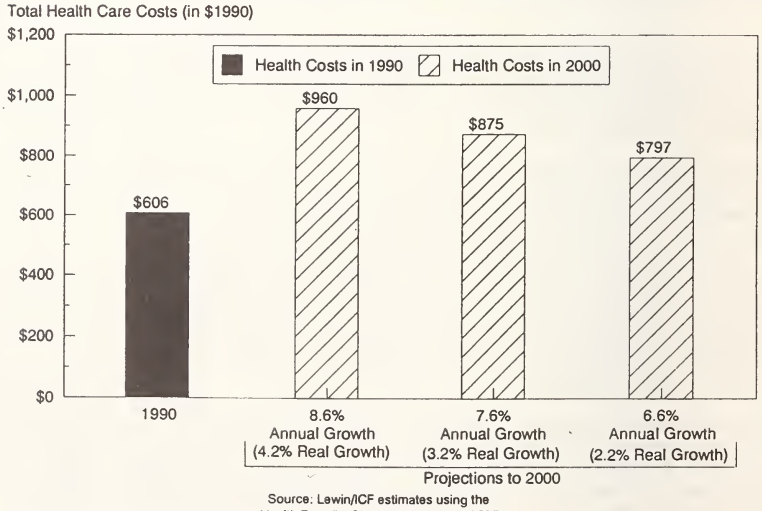
THE PARADOX OF INCREASED HEALTH SPENDING AND DECLINING ACCESS



Source: Lewin/ICF analysis of health spending data from the Health Care Financing Administration and March Current Population Survey (CPS) data for 1980 through 1990 adjusted for changes in Survey design in the March 1988-1990 CPS data

FIGURE 2

TOTAL HEALTH CARE SPENDING IN 2000 UNDER ALTERNATIVE SCENARIOS (IN BILLIONS OF DOLLARS)



Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)

FIGURE 3

CONTAINING SERVICE VOLUME MEANS INFLUENCING OVERALL PRACTICE PATTERNS

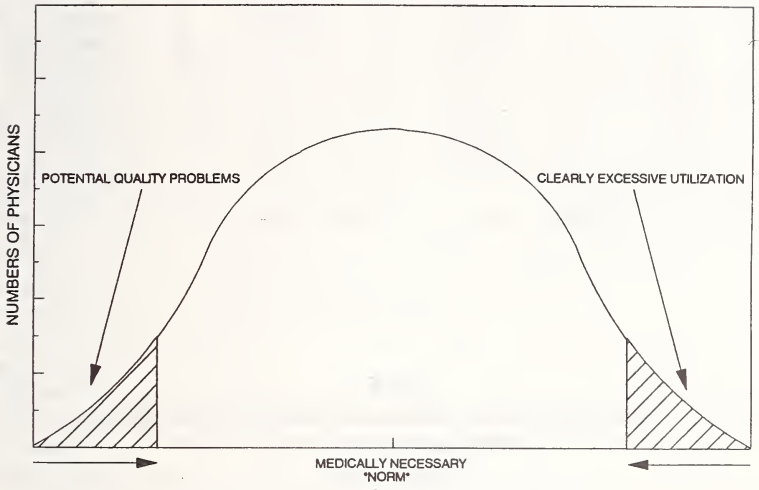


FIGURE 4

CHANGE IN NATIONAL HEALTH SPENDING
UNDER S.1227
(in Billions)

	1992	1993	1994	1995	1996	Five-Year Total
B. National Health Expenditures (current law)	$723	$791	$864	$945	$1,033	$4,356
C. Increased Utilization for Newly Insured Persons	--	$7.24	$7.92	$8.64	$13.60	$37.40
SAVINGS UNDER COST CONTAINMENT EFFORTS						
D. Administrative Savings Under Public Plan	--	(0.35)	(0.38)	(0.42)	(0.68)	(1.83)
E. Unnecessary/Ineffective Care						
• Outcomes Research	(1.70)	(3.71)	(6.45)	(7.97)	(9.86)	(29.69)
• Technology Assessment	(1.10)	(1.31)	(1.55)	(1.83)	(2.14)	(7.93)
F. Promote Competition	(0.40)	(0.87)	(1.31)	(1.44)	(1.71)	(5.73)
G. Encourage Managed Care						
• Pre-empt State Legislative Barriers	(0.10)	(0.22)	(0.36)	(0.39)	(0.43)	(1.50)
• Small Business Access to Managed Care	(0.10)	(0.33)	(0.48)	(0.52)	(0.57)	(2.00)
• Provide Managed Care in Public Program	--	(0.10)	(0.22)	(0.32)	(0.48)	(1.12)
H. Pre-empt State Mandated Benefits	(0.60)	(0.65)	(0.72)	(0.78)	(0.86)	(3.61)
I. Administrative Costs						
• Insurance Consortia	(0.05)	(0.11)	(0.24)	(0.39)	(0.57)	(1.36)
• Quality Improvement Agencies	(0.18)	(0.39)	(0.65)	(0.71)	(0.77)	(2.70)
• Small Group Insurance Market Reforms	(1.69)	(1.84)	(2.02)	(2.21)	(2.41)	(10.17)
J. Federal Health Expenditures Board						
• Hospital Cost	(1.10)	(1.20)	(1.31)	(1.44)	(1.57)	(6.62)
• Physician Cost	(1.50)	(1.63)	(1.76)	(1.92)	(2.10)	(8.91)
Total Savings	$(8.52)	$(12.71)	$(17.45)	$(20.34)	$(24.15)	$(83.17)
Net Change in National Health Spending	$8.52	$5.47	$(9.53)	$(11.70)	$(10.55)	$45.77

FIGURE 5

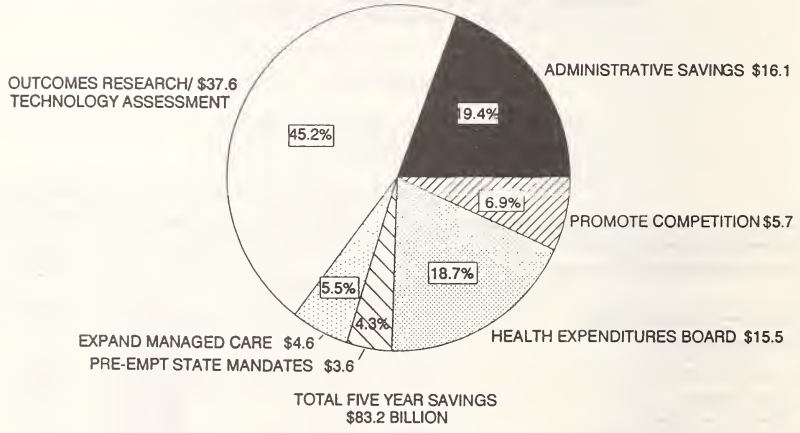
SUMMARY OF CHANGES IN NATIONAL HEALTH SPENDING UNDER S.1227
(in billions)

Year	*Savings Under Cost Containment Initiatives*	*Utilization Increase for Newly Insured*	*Net Change in Spending*
1992	*$(8.52)*	*--*	*$(8.52)*
1993	*(12.71)*	*$7.24*	*(5.47)*
1994	*(17.45)*	*7.92*	*(9.53)*
1995	*(20.34)*	*8.64*	*(11.70)*
1996	*(24.15)*	*13.60*	*(10.55)*
Five-Year Total	*$(83.17)*	*$37.40*	*$(45.77)*

SOURCE: Lewin/ICF estimates.

FIGURE 6

FIVE YEAR COST CONTAINMENT SAVINGS BY PROVISION 1992-1996 (BILLIONS)



The CHAIRMAN. Thank you very much. It has been very helpful testimony.

Mr. Sheils, I'd like to focus a little bit more on your analysis of the savings with the Federal Health Expenditures Board. You provide an estimate based on treating the board as an essentially voluntary program. If the board were viewed more like a mandatory rate-setting program, what savings might be assumed?

Mr. SHEILS. Well, of course, that is difficult to estimate because we don't know what expenditure levels the board would ultimately set. For illustrative purposes, we assumed that we achieved a one percent reduction in the rate of growth in health spending, which again is fairly conservative. That would give us a savings of about $89 billion over the 5-year period.

If we were to slow the rate of growth in health spending by 2 percent, which means that health care costs would grow at a rate about 50 percent greater than inflation, we'd be looking at savings over that period of about $150 billion.

So it really depends on how aggressive the board chooses to be in setting these rates.

The CHAIRMAN. Is that your sense as well, Professor Adams?

Mr. ADAMS. Yes. I have no doubt that mechanisms are needed to in some sense deal with a world in which we have imperfect markets, lots of market power, and we need to respond to that.

I would argue like Mr. Sheils that it is very, very difficult to estimate how effective such a program will be, and a lot of it really depends on how strong a position and how "voluntary" some of these rate procedures are going to be.

The CHAIRMAN. Mr. Sheils, the States are also encouraged to establish their own cost containment programs. Did you assume any savings from these programs?

Mr. SHEILS. We again were very conservative here, and we assumed no savings associated with that provision. And the literature shows that in States where they have had all-payer rate-setting systems, the rate of growth in health spending for hospital care has been slowed by as much as 30 percent. And if we are successful in getting the States to participate, we can look forward to some fairly substantial savings. It takes a while to get these programs off the ground, but in the long haul they can prove very effective.

The CHAIRMAN. I believe you had a look at the GAO study that purports to show $63 billion in a single-payer model. Have you had a chance to look at it, and what conclusions did you reach on that?

Mr. SHEILS. Yes, we have. We have done some work of our own, which in fact was cited in the study. The GAO study does us a service, of course, by pointing out the differences in the administrative costs between ours and the Canadian system. We, however, estimate that the administrative savings from the Canadian system would be about half of what is estimated by GAO. But we estimate, too, that these savings would be more than offset by utilization increases.

One of the key elements of the Canadian system is that there is first dollar coverage for virtually everything—no deductibles, no copayments. And quite simply, that simplifies the system by fixing it so that you get your payment from just one source instead of trying

to get part of it from the household and then the rest of it from the insurer.

When you have first dollar coverage, you have a fairly sizeable increase in the demand for health services. If you have a deductible today, and you get a cold, you say I'll hold off for a while. But if there is first dollar coverage, and it is free, there is really no reason for you not to go to the doctor.

We estimate that the utilization increase would more than offset the savings for a net increase in health spending of about $17 billion.

The CHAIRMAN. What are the administrative expense comparisons; did you get into that?

Mr. SHEILS. Yes. The administrative expense really boils down to two pieces—the insurer's cost of administering the insurance policy, and then the provider's cost of dealing with the insurer. Quite simply, it is the cost of filling out the forms, on the provider's side, and the cost of processing them on the insurer's side.

When you have a single-payer system, you have a much lower administrative overhead. For example, let's talk about our own system for a minute here. Administrative costs in private health insurance equal about 11 percent of claims. So 11 percent out of every dollar you pay in private health insurance goes to administration.

In Medicare, the administrative overhead is around 2.7 percent, so it is just under 3 cents per dollar of claims under Medicare.

If you go to a large, centralized, single-payer system, you can look forward to savings in insurer administrative costs. Also, on the provider's side, there are also a number of simplifications that can result because you are dealing with just one set of forms, you are dealing with just one set of rules, and when you submit the form it is much more likely that you will have it filled out properly, you'll get prompt payment, and so on and so forth.

One of the chief savings, though, that you find in the Canadian system—I think it is important to discuss this, too—is that in the Canadian system the hospitals are given an operating budget. They are just told you are going to have to serve everybody who comes through the door for this much money, and that's it. There is no claims processing there. This is your budget. You don't have to submit a claim at all for anybody.

I think it is important to point out, though, that the Canadians are now moving toward a DRG system like our own Medicare DRG system. In fact my partner just returned from Toronto where he was working with them on just that. They are moving toward an administrative structure which looks more like ours. They are also trying to implement managed care programs, and there is another important thing. You have got to pay the people who are managing the care. You have got to pay the case managers. What it boils down to is that in managed care you've got to spend money to save money.

We spend a lot of money to try to save money in our system through managed care. In Canada they have very, very little of this, and they are hiring a lot of American firms, ours included, to go up and help them develop managed care systems.

Administrative cost is a little like cholesterol—there is good cholesterol and bad cholesterol. It is the same with administrative cost—there is good administrative cost and bad administrative cost. The administrative cost associated with trying to direct patients to more effective modes of care is what I would call the good administrative cost.

I am afraid that in the studies we have seen done here, the two are mixed—the administrative cost associated with inefficiencies of underwriting practices, which this bill seeks to minimize, by the way, should not be lumped into the same cell as the administrative cost of managed care.

So I guess this is one of the fundamental problems I have had with the discussion of administrative cost in Canada versus our system.

I'd also like to point out—and I don't mean to Canada-bash here, because I think there is an awful lot to learn from the Canadian system, and there are elements of it that we should pay close attention to here—but a Canadian system in the United States would have an annual budget of about $600 billion. Now, that's larger than the entire economy of Canada. It is an enormous undertaking.

It seems to me that nationalizing our health care financing system to save on administrative cost is really out of proportion to the task at hand. It seems to me there is much that could be accomplished through insurance market reform, electronic claims processing, simplification of small group administration, and quite frankly, simplification of government health insurance programs.

I don't mean to Medicare-bash, but Medicare administrative practices are—well, providers will tell you there is quite a bit involved in filling out a claim, that the process is quite arduous, and they will argue that it is wasteful. So there is much that we can do to help that issue right in our own house here.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you.

I have a number of questions, but I have to leave at 1:00. In this discussion, I want to make it real clear that I don't necessarily view these proposals as being in conflict with one another. I think we are all interested in cost control, and I really look forward to working with the chairman. Where the Health Expenditure Board fits in under the HealthAmerica proposal and how that all gets developed is important to me.

I would like to talk about the single-payer plan, if I could, Mr. Sheils. First of all, you have testified today about some of your calculations on the GAO report. Have you published these calculations yet?

Mr. SHEILS. We are going to produce a paper on it very shortly.

Senator WELLSTONE. I'd be very interested in that analysis. I feel at a bit of a disadvantage not being able to have it before me.

Mr. SHEILS. Right. It was cited in the GAO study.

Senator WELLSTONE. The second thing I really liked about what you said, and I think I want to try to amplify this point, is that I don't know anybody who is advocating a wholesale adoption of the Canadian system. You take the parts that you think might be helpful, and you reject other aspects of it.

What we have here is a cost estimate of $83 billion over 5 years, with the leadership bill, an important piece of legislation; we have the GAO study, which says $67 billion in 1 year. But then what you've just said is that actually, by your calculations, it would be half, that you think it is overinflated, and really we are talking about half. But that is $34 billion a year, which is still a significant amount of money—and that is all administrative.

Mr. SHEILS. Yes.

Senator WELLSTONE. In your estimates about the leadership bill, we're talking about $16 billion over 5 years in savings in administrative costs, and we're talking about $34 billion in 1 year.

Mr. SHEILS. Yes.

Senator WELLSTONE. Then what you went on to argue—and I just want to be clear about this—is but that could be offset by overutilization.

Mr. SHEILS. Yes.

Senator WELLSTONE. I want to come back, in the spirit of harmony and understanding where we are heading here, to the point you just made which is that clearly there are some aspects of the Canadian system that are very good; others we might not want to adopt.

To have single-payer doesn't mean that we don't adopt some co-insurance and deductible requirements that are in this bill. I think you are presupposing that just because somebody is interested in a single-payer plan or something that goes in that direction, we might not be interested in other aspects of what is in this proposal. We're not talking either/or here; I want to remind you of that.

The second point I want to remind you of is that I don't know quite where to draw the line on co-insurance and deductibles, but I do know that sometimes it is not such a bad thing if people overutilize, if what we mean by that is that they haven't been utilizing health care because they find those payments to be so regressive, especially the most vulnerable citizens, which this particular Senator, Senator Kennedy, has fought for ever since he has been here.

So I don't know where we draw the line on that, but I did want to remind you of that. Then the final point is when you say that it would be offset by utilization, I don't know how we quantify this, but I'm sitting here trying to conceptualize it, and I'm thinking to myself that on the other hand, if what would happen is that people who right now are without insurance or are underinsured would utilize at the front end, if you will, there could be enormous cost savings in terms of preventive care. I don't know if you factored that in. I'd have to see your study. But again I would remind you that to say we want to move toward a single-payer does not necessarily mean therefore we adopt everything that's in the Canadian system, and it doesn't mean that we are without co-insurance and deductibles, although I have questions about where that fits in and what the income effects are.

Does that make sense?

Mr. SHEILS. It makes a lot of sense, and I think that there is a lot of creative thinking going on now about programs which would use the structure of the existing system and still funnel through some sort of single-payer mechanism.

So there is a lot of creative thinking going on in that direction. I think the important thing to remember about the co-insurance and

deductibles, though, is that as soon as you introduce them, you get the provider into the situation where they have to collect from here and then collect from there. That is when the savings start to disintegrate.

An important thing to remember is that managed care efforts, which account for some of the differences in administrative costs, are intended to eliminate unnecessary utilization. To the extent that they have been effective in doing so, if we eliminate those mechanisms, then we increase the incidence of ineffective care, not reduce it.

One of the things we do know about the Canadian system is that the physicians in Canada are performing more procedures per individual than in the United States. We know that they have longer lengths of stay in the hospital than we do in the United States.

The reason we have shorter lengths of stay is largely due to DRG's, which are an expensive thing to administer. The reason why we are doing fewer procedures may in part be related to the fact that we have precertification programs, and we have managed care programs, which try to limit that utilization.

While there are a lot of things about the single-payer model that we should try and incorporate where we can, I think it is important to get away from these Canada/United States comparisons. It is an apples-and-oranges comparison. We do things in a different way. We are a different culture. We don't have the same sort of central government they do. In the United States, it is separation of powers, the States do this, and it is a sort of nobody-is-in-charge sort of thing; that's not the sort of system you have in Canada.

Senator WELLSTONE. Just as you said, I don't think it is helpful to compare Canada/United States—I would not accept your last characterization about their system of government. But I think you are right. I don't think it is one or the other.

A final point that is something I want to ponder—I want to quote from the CBO: "Most other industrialized countries do not rely heavily on cost-sharing as a mechanism for cost containment, and they are better at controlling costs than the United States," just in terms of how we look at this comparatively speaking.

Mr. SHEILS. That's an excellent point. I think there is a philosophy on cost containment that we have tried to advance over the years. Basically, we feel the system should move toward an economically disciplined system, that is, a system where everybody has an incentive to try to watch the costs. The insurers should be provided with incentives to do the utilization review. The providers can be put into payment structures where they have an incentive to minimize the unnecessary utilization. Households could be given a series of incentives through cost-sharing as part of the equation. The government is involved through technology assessment and some modicum of regulation.

It is this business of triangulating on a solution as opposed to trying to put our eggs in any one basket that I think is vital. We have a different culture. We have a different attitude toward expenditures on health care. We have a voracious appetite for health care. And it is going to take a different formula to contain the growth in cost in the United States and elsewhere.

There is one other point I want to make. GAO points out that the Canadian system could offer long run savings, more savings in the next year and more after that. One of the reasons is that they have the expenditure target system. There is no reason why we couldn't implement an expenditure target system in any health care reform package. In fact we could implement it today without health reform. You could set rates for everybody, everybody would be reimbursed on the same set of rates, and you'd structure those rates so we'd hit our targets every year. It is theoretically possible—it would be a nightmare to administer, but it can be done.

I don't think it is appropriate to link the long run savings associated with targeting in Canada with Canada, the Canadian model itself. That is a separate element. It is budgeting, it is targeting your expenditures. And as I said, I think you could apply that anywhere. There are very different systems throughout the world using expenditure targets.

Senator WELLSTONE. Thank you.

The CHAIRMAN. We'll submit some questions for response in writing. We are very grateful to both of you, and welcome you back.

The committee stands in recess.

[Whereupon, at 1:05 p.m., the committee was adjourned.]

HEALTHAMERICA: VIEWS OF BUSINESS, HEALTH CARE PROVIDERS AND THE INSURANCE INDUSTRY

WEDNESDAY, JULY 31, 1991

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Simon, Adams, Wellstone, Hatch, and Thurmond.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

My presence will be necessitated on the floor shortly, and Senator Simon will chair the remainder of the hearing. I apologize in advance to the witnesses, but I look forward to reading all of their testimony.

I will include my statement in its entirety in the record as if read. Each of our witnesses knows what is in the statement, and so we'll move right along.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Our hearing today will give a number of major participants in the health reform debate a chance to express their views on the nation's health care crisis and the HealthAmerica bill we have introduced.

As we listen to the testimony of our witnesses today, several things will stand out. First, there is widespread agreement that comprehensive reforms of our health care system are necessary. This is the first time in all the years that I have been working on this issue that there has been general agreement by these major groups on this fundamental point.

Second, almost every group testifying will find many things in the HealthAmerica program that they can support. Business will be pleased with the strong emphasis on cost containment, although there may be differences on some of the details. Providers will support the need to guarantee coverage for every American. And insurers will recognize the need for significant reforms in the way health insurance is priced and sold.

At the same time, some differences will be apparent. Business groups are understandably reluctant to support additional requirements on business. Some businesses will wish to strengthen the cost control provisions of the bill. Some health care providers are concerned that the cost containment provisions are too onerous. Insurers would like less reliance on a public program and more on the private sector, and may regard the insurance industry reforms as too far-reaching.

No program is likely to satisfy all these divergent viewpoints. But as a recent poll by Metropolitan Life of top business executives, health care providers, and labor leaders indicated, the kind of program embodied in HealthAmerica is the only one that is broadly acceptable to all the key groups involved.

The testimony today, despite continuing differences, will show that we are far closer to a consensus than we were even a year ago. I expect this legislation to be reported out of our Committee after the August recess. Senate Majority Leader George Mitchell has said that the Senate will vote on the bill next year.

I look forward to working out our remaining differences with the groups represented here. And I encourage all those that have suggestions and concerns about this bill to join us in finding reasonable compromises to address their needs.

But no one should make the mistake of just saying no to comprehensive reform—because the price of that kind of posture is to be left out and left behind. The American people cannot and will not wait for action to guarantee adequate health insurance coverage at a price they can afford.

[The prepared statement of Senator Hatch follows:]

Prepared Statement of Senator Hatch

Mr. Chairman: This is the second hearing we have held on S. 1227, legislation to mandate employers to offer health insurance to their employees. As one might predict, the issues are crystallizing. How much will it cost? Who will pay for it? Will it work?

We have all heard the same testimony. Have we reached the same conclusions? I doubt it.

Rate regulation is wrong; it will not work. Rate regulated states have higher hospital costs than non-regulated states. Will we learn nothing from history?

I am reminded of a William Faulkner line, "The past is not dead. It is not even past."

It is clear that the "Mitchell Mandate" will lead to lost wages and lost jobs for American workers. Last week, one witness talked about effective cost containment mechanisms leading to a contraction of our health care demand. Then the witness offered the expansion of health care jobs as an amelioration for the job loss associated with pay-or-play! It is easy to have it both ways unless you live in a world where there are real people, real families to support—with earnings from real jobs, real payrolls to be met by real employers.

The proposed public pool could expand well beyond its intended enrollment. One witness last week suggested 15 million workers would move from employment-based health insurance to the public

pool. Other estimates suggest that as many as 60 million workers who make less than $20,000 per year may be forced into these pools. It may be cheaper to "dump" them into public programs than to provide private health benefits. And, as was clearly outlined last week, each worker added to the public pool is more expensive to insure than the previous covered worker. Then, very low risk individuals ultimately remain in the private insurance setting. The political pressures to make rationing decisions at the federal level will be overwhelming under such circumstances.

Costs to the federal government, forced by such increased federal mandates and by numbers of workers dependent on the public pool, will spiral out of control. The tax rate on small employers will have to increase rapidly to meet the costs. As those tax rates go up, more individuals will get dumped. More jobs will be lost. Workers real wages will be constrained. Freedom of choice and flexibility will be lost. Where will our health care system be? I predict it could become a shambles.

Let's do better. Let's find better solutions that will result in less havoc and that will build on our current system of incentives. I am committed to universal access and to finding those solutions.

I look forward to the testimony of our distinguished panelists today.

The CHAIRMAN. Our first panel includes representatives of three major business organizations deeply involved with the health care issue. Jerry Jasinowski is president of the National Association of Manufacturers. Jeff Joseph is vice president for domestic policy at the U.S. Chamber of Commerce. Dr. Mary Jane England is president of the Washington Business Group on Health.

We'll start with Jerry Jasinowski.

STATEMENTS OF JERRY J. JASINOWSKI, PRESIDENT, NATIONAL ASSOCIATION OF MANUFACTURERS; JEFFREY H. JOSEPH, VICE PRESIDENT, DOMESTIC POLICY, U.S. CHAMBER OF COMMERCE; AND DR. MARY JANE ENGLAND, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. JASINOWSKI. Thank you very much, Senator Kennedy. I'll be as expeditious as I can given your own schedule and the usual tight schedule here.

We are very pleased to be testifying on behalf of the National Association of Manufacturers. I am the president, and we have about 12,500 members who, according to a recent survey, 98 percent of whom provide health care coverage. But the future of such coverage is threatened by staggering cost increases.

Let me start out, Mr. Chairman, by congratulating you on your leadership in this area. I think that the position from which you have moved in terms of your original bill to this particular bill—that is to say, S. 1227, HealthAmerica—is an important step forward in terms of the health debate in this country.

You and your colleagues have worked hard to increase the cost containment and the quality aspects of this legislation, and I think that is a major step over where you were before. The other aspects of the bill, even the "pay or play" provisions, I think are more interesting than your earlier health care package.

We therefore are extremely enthusiastic about the quality aspects of what you have in your current legislation. Indeed, targeting quality problems we believe is the central issue that ought to be addressed as we move forward in health care legislation. The reason for that simply is that while access and quality and cost containment should all move together, the access aspect of this has been emphasized throughout the last 5 years of debate, and it is only in the last year that the cost and quality issues have come to the foreground, and the extent to which your legislation puts emphasis on that reflects that movement.

Now, why is it that quality, in the brief time I have, and improving the quality of the health care system is so important? The reason for this is that unless we reduce the waste and inefficiency in the current system as we move forward toward greater access, we are not going to be able to bring down the costs of this system.

My testimony outlines—and I'd like to ask that the full statement be included in the record——

The CHAIRMAN. It will be so included.

Mr. JASINOWSKI [continuing]. That the Rand Corporation estimates quality problems increased costs as much as $75–$200 billion annually, to give one example. A study of hospital admissions found that 23 percent were unnecessary and that 17 percent were avoidable, using ambulatory surgery. Both of these numbers come from the Rand Corporation. Every day, 900 new medical malpractice suits are filed. Awards average $300,000 per case. This has forced doctors to pursue the defensive medicine that emphasizes quantity rather than quality. I think that what you have in your bill is some progress there, although since Senator Hatch is here, I would just say we would urge that we move forward toward Senator Hatch's bill in terms of strengthening the malpractice provisions of this bill, Senator Kennedy.

Many employers have begun to take action on this quality front. Navistar Corporation, which spent $175 million in 1990 on health care, recently did a survey and found that again, of the hysterectomies performed between 1988 and 1989, 74 percent were either questionable or inappropriate.

I could go on with the numbers, Senator. The case is clear. We are wasting anywhere from $75–$200 billion in the American health care system because we have not applied the quality procedures there that we have applied in manufacturing and many other areas.

This legislation has important steps to address that. To summarize those, I simply refer to the enhanced Federal investment in outcomes research and practice guidelines, expanding the mission of the Agency for Health Care Policy and Research, the assisting of small manufacturers to participate in managed care programs and preempting State laws restricting managed care so that these companies can move toward improved quality.

The uniform cost and outcomes information, similar to that being provided under the Pennsylvania law, is another way to improve quality and cost-effectiveness, as is the elimination of costly State mandates to enable insurers to market basic research plans and again, as I said, the tort reform that you have in the bill and which I would ask you to strengthen.

We still have a lot further to go in the quality drive. Much of that must be done in the private sector, where users and providers have to adopt a quality culture. But in any event, Senator, you and your colleagues have moved us considerably forward by putting emphasis on that, which I daresay was scarcely mentioned in the earlier legislation. That has major implications for cost reduction because the way you get cost reduction primarily is to get the waste out of the system.

Having said that, what I would turn to next is to comment a bit on some other aspects of the bill, and I think there we have more difficulties, and we cannot support the legislation as it now stands. Our difficulties range from the whole area of expenditure targets and how workable that is in terms of the ability to come to agreement on what those expenditure targets are, the extent to which we would be imposing government decisions which the market might do somewhat better, aspects of the all-payer system that you have here for which the evidence is unclear as to how effective it is in holding costs down.

Finally, let me turn to the "pay or play" proposal which has gotten so much attention and which is at the heart of your bill.

We cannot support it at this time because it has a number of deficiencies, the most important of which is that it would put too heavy a burden on small firms; that it appears to be priced out at a price level that underestimates what health coverage would cover, which will cause a major shift, we think, from employers providing insurance to the government taking it over to much too large a degree, and the fact that there is reduced flexibility in the plan with respect to what benefits can be offered and negotiated by the private sector.

Having said that, it is clear that within my own membership there is substantial support for the "pay or play" proposal because it would reduce cost-shifting; it would put more responsibility on individuals and individual employers to make decisions; it would spread access out somewhat and have somewhat more flexibility than the earlier mandates that you had in your earlier legislation.

We have a task force which is working on this now. It is working through our various committees. I don't really know how the NAM will finally come down, but I think it is interesting that the proposal is getting the kind of debate that it is.

I would say the biggest problem by far is its impact on small firms and the fact that the proposal seems to be underpriced and will cause a major shift into the government area.

I could go on with other things, Senator, but I have taken more than enough time. Let me again congratulate you and your colleagues on the leadership shown here, particularly with respect to quality improvements. We'd like to work with you on the other aspects of the bill, including the more controversial aspects of expenditure targets and "pay or play". Thank you very much.

[The prepared statement of Mr. Jasinowski follows:]

Prepared Statement of Mr. Jasinowski

SUMMARY

Health care reform must be based on a strategy that targets quality problems by improving system efficiency, thus making more resources available to expand access for the approximately 30 million uninsured Americans. Provisions of S. 1227—expansion of outcomes research and practice guidelines, enhanced role for the Agency for Health Care Policy Research, technology assessment, promotion of cost effective managed care and improved purchaser information—are important steps toward these quality goals. Reform of the small group market for insurance and elimination of costly state mandates should help more small firms gain access to coverage. Tort reform provisions must be strengthened to provide a federal framework for reform rather than a patchwork of state grants. All-payer systems and employer requirements to provide coverage or pay into a public plan continue to cause us concern. We are studying these provisions within the context of a health system reform policy that will be supported by our member companies. At this time, however, we cannot support S. 1227 as written.

A quality improvement strategy must be central to any system reform because we are wasting too many resources in our health care system. In this regard, NAM recommends the following:

1. Purchase health care based on value, rather than on price alone. Medicare and other government-funded health programs can provide lessons for the private sector. For instance, the federal government should selectively contract for specific services with effective, efficient providers for the Medicare/Medicaid populations.
2. Make the Agency for Health Care Policy and Research (AHCPR) the national clearinghouse for quality-care information. All efforts to define, measure and improve the quality of care on a national scale should be coordinated through the AHCPR.
3. Require that new technologies demonstrate effectiveness/ appropriateness and cost/benefits, using the same standards that are applied to procedures, as a condition for reimbursement under Medicare and Medicaid. Make available such information to private employers and other payors.
4. Require that all states enact legislation mandating a uniform minimum data set for collecting hospital and physician treatment-outcome data and related cost; disseminate results to the public through a national data bank. The database and query system software must have adequate security mechanisms to ensure privacy and confidentiality.
5. Fund a national research agenda that addresses health quality improvement; include physician and medical research initiatives to improve quality of care, and medical practice guidelines validated through research on patient outcomes and patient satisfaction.
6. Support the development of educational systems to help all interested parties make the best use of the new quality-based system.
7. Encourage health care providers to acknowledge that health care quality can be measured and cooperate fully with initiatives to measure and improve standards of care. They must work actively with purchasers and others in the community to reward healthy lifestyles and minimize health risks.
8. Encourage patients to do everything possible to ensure a healthy lifestyle, prevent illness and injury, and support family and friends in their efforts to improve health.

Mr. Chairman and members of the Senate Labor and Human Resources Committee, I am Jerry Jasinowski, President of the National Association of Manufacturers. Accompanying me is Sharon Canner, NAM's Assistant Vice President of Industrial Relations. I am pleased to appear today on behalf of our 12,500 member companies, 8,500 of whom have fewer than 500 employees. Over 98 percent of these firms, according to a recent survey, provide coverage for both their workers and dependents, but the future of such coverage is threatened by staggering cost increases which cannot be sustained.

We commend you Mr. Chairman for convening this hearing today to explore solutions to this problem and the related issues of quality and access as addressed by S. 1227 (HealthAmerica). As we indicated earlier upon introduction of this bill in June, "HealthAmerica" is a good first step and helps us begin to address the problems of

our ailing health care system. However, we cannot support the bill as currently written.

We are enthusiastic about the quality improvement provisions of "HealthAmerica"—indeed, targeting quality problems is the key to improving system efficiency and making more resources available to expand access for the approximately 30 million Americans without health care coverage. Our belief in quality improvement as a key policy strategy is outlined in a recent NAM publication "Buying Value in Health Care" which I request be included along with my full testimony in the hearing record.

SUCCESSES/FAILURES OF THE U.S. HEALTH CARE SYSTEM

Some 85 percent of Americans under 65 are covered by private sector health insurance with nearly three-quarters obtaining coverage through their place of employment. Approximately 34.3 million elderly and disabled persons are covered by Medicare, but only about 42 percent of those at the federal poverty line qualify for Medicaid, a program initially established to assist the poor in obtaining health care. Medical advances, e.g., new life extending cancer treatments, care for premature newborns, noninstrusive imaging devices that eliminate some diagnostic surgeries, psychotropic drugs that decrease the need for hospitalizations, mainstreaming the disabled, and other scientific gains, have made the United States the envy of other nations. Yet critical quality, cost and access problems threaten the future viability of the system. For example:

—One in five children have no health care coverage, "yet personal health care per child is estimated at only $745 annually. (National Association of Children's Hospitals and Related Institutions).
—The Rand Corporation estimates quality problems increase costs an estimated $75 billion to $200 billion annually.
—Hospital-acquired infections occur in approximately five percent of patients each year and about one percent of such infections—20,000 a year—are fatal. (U.S. Centers for Disease Control)
—Coronary bypass surgery consumes about one out of every $50 dollars spent on health care in the United States and is performed 300,000 times a year. One-half of such surgeries should not be performed at all according to researchers (Andrew Pollack, *New York Times,* April 1991).
—Physicians who own x-ray and ultrasound machines perform 4 to 4.5 times as many tests as physicians who refer patients to radiologists and the cost of these tests is also higher than that performed by radiologists. (Bruce Hillman, University of Arizona).
—A study of hospital admissions found that 23 percent were unnecessary and that 17 percent were avoidable using ambulatory surgery. (Rand Corporation)
—Everyday 900 new medical malpractice suits are filed. Awards average $300,000 per case. (U.S. Senate Committee on Labor and Human Resources)

While these examples point to the problems, it should be noted that some employers have taken aggressive action to improve the health care quality and value of benefits provided to their employees. Navistar International Corporation, which spent $175 million in 1990 on health care, recently conducted an audit of various procedures covered under its medical plans. Of the hysterectomies performed in 1988 and 1989,26 percent were found to be appropriate, 41 percent were questionable, and 33 percent were inappropriate. The per case cost of $9,000 to $10,000 represents a significant waste of money given that 74 percent of such procedures were either questionable or inappropriate. Based on this information, Navistar is identifying quality providers, developing selective contracts and establishing comprehensive systems to assure continuous quality improvement in care. Other employer examples are described in "Buying Value in Health Care."

HEALTHAMERICA (S. 1227)

HealthAmerica endeavors to address some of the issues of quality, cost and access highlighted above. In the following sections we comment on specific provisions of S. 1227.

Quality Improvement and Cost Containment

An enhanced federal investment in outcomes research and practice guidelines should help improve health care quality and cost management overall. Expanding the mission of the Agency for Health Care Policy and Research (AHCPR) to include services delivered to both Medicare and non-Medicare populations is important as

well as efforts to analyze the appropriateness of new and existing technologies. In addition, we urge that AHCPR become a national clearinghouse for quality care information readily accessible to both the private and public sectors and that there be close coordination with private groups active on these issues such as the Group Health Association of America, the Health Insurance Association of America and the Blue Cross and Blue Shield Associations.

Assisting small employers to participate in managed care programs and pre-empting state laws restricting managed care should help to further encourage economical and efficient service delivery. The availability of managed care as well as fee-for-service in public programs is important. Minimal cost-sharing and other incentives should be used to strongly encourage public participants to enroll in managed care as opposed to fee-for service.

Uniform cost and outcomes information similar to that being provided under the Pennsylvania data law would be a valuable tool for purchasers in making cost-effective buying decisions. Rather than a federal program per se, consider establishing federal guidelines (a uniform minimum data set) and allow states flexibility in structuring such laws to reflect local differences and relationships among providers and purchasers. NAM supports state data laws to require uniform cost and quality data as a means to identify quality providers. Ultimately, the goal is a health care delivery system that rewards cost-effective providers for quality and efficiency, rather than quantity.

Eliminating costly state mandates will enable insurers to market basic health plans to small employers and hopefully lower insurance costs for these firms. NAM supports the elimination of state laws requiring coverage of specific medical procedures/treatments and/or classes of providers. We also support reform of coordination of benefit rules to assure that dual coverage does not result in reimbursement over 100 percent of expenses. Coordination of benefit rules is not addressed in S. 1227.

Tort reform of the medical liability system must be approached at the federal level. Grants to encourage individual state reforms as proposed by S. 1227 will likely result in a continued patchwork of laws. We urge the Committee to support S. 489 (Hatch RUT) which includes limits on attorney contingency fees, periodic payments' for awards over $100,000, a $250,000 ceiling on noneconomic damages and offsets for collateral source awards.

S. 1227 would establish an independent federal board to set national expenditure goals, in total and by sectors of the health care industry and by states and regions. The board would convene providers and purchasers to conduct negotiations on rates and other methods of achieving the goals. Providers and insurers who fail to meet the goals would be subject to civil penalties and prohibited from participating in Medicare and AmeriCare. Negotiations would be based on an all-payer rate system. State consortia are also established for purposes of setting up uniform billing procedures for small employers.

National expenditure targets are certainly an interesting idea. The problems of achieving the goals are enormous, however, with the various provider groups lobbying to adjust the numbers. Lessons with Medicare's DRG system are examples of the difficulties of federal rate-setting efforts.

S. 1227 would require payers, providers, and insurers to negotiate payment rates via an all-payer system to meet the expenditure targets. Experience with all-payer systems has been limited to a few states and from evidence available, it is unclear whether this approach is effective in holding down costs. Some of our members believe all-payer systems have merit and should be part of a comprehensive reform strategy. Others are equally convinced that all-payers will not work and will thwart employer efforts in dealing directly with providers to gain better control over costs. We are continuing to look at this issue within the context of overall reform.

HealthAmerica's state consortia with exclusive state boundaries raise concerns where there is significant traffic across state boundaries, e.g., the Washington, DC-Virginia-Maryland area. The issue of multiple state jurisdictions must be addressed.

Improve Access/Reduce Cost-Shifting

Cost-shifting from government to the private sector and within the private sector has resulted in increased employer costs and fewer people receiving care who should be covered by government programs. Only 42 percent of those persons at the federal poverty level are eligible for Medicaid due to various state eligibility laws. Also, some individuals decline coverage whose subsequent care is often subsidized by private employers.

S. 1227 endeavors to deal with these access and cost-shifting problems through (1) establishment of AmeriCare, a public program available to all regardless of income; (2) individual responsibility to accept coverage; (3) reform of the small group market

for health insurance; and (4) requirement that employers provide employee and family coverage or contribute to a public plan.

Expanding coverage to all can be expected to lessen the cost-shift and small group market reform will help to improve accessibility for small firms in obtaining group health coverage. Individual responsibility is also an important strategy in this effort.

The employer requirement to provide benefits or pay into a public program continues to be a concern for us. While we are on record in opposing this concept we have members on both sides of the issue. Although this approach does not constitute a straight mandate per se and would offer a "choice" to employers, the tax would still fall disproportionately on small businesses which are struggling to survive economically. We are studying the issue within the context of broad system reform, that is, assuring that other system changes are made and that all parties—providers, insurers, labor and government—are sincere and commit to taking a flexible approach in solving this problem.

The estimated 7 to 8 percent payroll tax will be insufficient to finance AmeriCare once it becomes fully operational. The bill is silent on other financing means. Further, since the payroll tax is substantially less than an estimated 15 percent of payroll needed to finance health care coverage, the cost of AmeriCare could well become prohibitive if most employers declined to offer coverage.

It is our understanding that employers may choose to pay the tax for certain portions of their workforce while providing benefits to others. Of course, the employer may elect to place all employees in the public plan. In such cases, employees who consider this practice discriminatory, may sue their employer for damages under the statute.

Surely, this committee is well aware of the cost of litigation both to plaintiff and defendants and to the time consumed in such cases. It is hoped that the final bill is cognizant of this fact and takes measures to assure the goal of expanded coverage versus lengthy and costly litigation.

CONCLUSION AND RECOMMENDATIONS

We believe that health care reform must be based on a strategy that targets quality problems by improving system efficiency making more resources available to expand access for the approximately 30 million uninsured Americans. Provisions of S. 1227—expansion of outcomes research and practice guidelines, enhanced role for the Agency for Health Care Policy Research, technology assessment, promotion of cost effective managed care and improved purchaser information—are important steps toward these quality goals. Reform of the small group market for insurance and elimination of costly state mandates should help more small firms gain access to coverage. Tort reform provisions must be strengthened. We are continuing to review all-payer systems and employer requirements to provide coverage or pay into a public plan within the context of overall system reform.

A quality improvement strategy must be a key part of system reform. In this regard, NAM recommends the following:

1. Purchase health care based on value, rather than on price alone. Medicare and other government-funded health programs can serve as models for the private sector. For instance, the federal government should selectively contract for specific services with effective, efficient providers for the Medicare/Medicaid populations.
2. Make the Agency for Health Care Policy and Research (AHCPR) the national clearinghouse for quality-care information. All efforts to define, measure and improve the quality of care on a national scale should be coordinated through the AHCPR.
3. Require that new technologies demonstrate effectiveness/ appropriateness and cost/benefits, using the same standards that are applied to procedures, as a condition for reimbursement under Medicare and Medicaid. Make available such information to private employers and other payors.
4. Require that all states enact legislation mandating a uniform minimum data set for collecting hospital and physician treatment-outcome data and related cost; disseminate results to the public through a national data bank. The database and query system software must have adequate security mechanisms to ensure privacy and confidentiality.
5. Fund a national research agenda that addresses health quality improvement; include physician and medical research initiatives to improve quality of care, and medical practice guidelines validated through research on patient outcomes and patient satisfaction.

6. Support the development of educational systems to help all interested parties make the best use of the new quality-based system.
7. Encourage health care providers to acknowledge that health care quality can be measured and cooperate fully with initiatives to measure and improve standards of care. They must work actively with purchasers and others in the community to reward healthy lifestyles and minimize health risks.
8. Encourage patients to do everything possible to ensure a healthy lifestyle, prevent illness and injury, and support family and friends in their efforts to improve health.

We would be pleased to respond to your questions.

The CHAIRMAN. Thank you for those very instructive and helpful comments. Mr. Joseph.

Mr. JOSEPH. Thank you, Mr. Chairman.

I am Jeff Joseph, vice president for domestic policy at the US Chamber. I am pleased to be here and hope our whole statement could be put into the record. And in the hopes of shortening this panel for everyone's benefit, I want to generally align myself with the comments of my colleague from the NAM and mention—which is not new news—but it has been 20 years since the Chamber has been coming here, and the business community has been very concerned about some sort of role that the Federal Government can or should play in straightening out the health care system.

Twenty years ago, business was spending $12 billion to finance group health benefits for employees; today, that number is almost $150 billion, and inflation only accounts for about $25 billion of those numbers. So we have a serious series of problems that continue to get worse, and we commend you also for finally merging the issues of cost, quality and access. You need to address them all together.

The "pay or play" issue is one that still gives us very grave concern. It is seen, especially to the bulk of our membership who are small business, as a mandate, while giving a small business the opportunity to cap health benefit costs at maybe 7 or 8 percent of payroll. We think that the proposal sets a dangerous potential for adverse selection against the public insurance program and for more cost-shifting to larger businesses, and we are concerned about that.

We also think in addition, as concerned as companies are about health care cost increases, most are still not prepared to believe the answer lies in regulating prices and capping total expenditures under a Federal program.

We have all learned that when the Federal Government drives health policy, it invariably becomes budget policy, and an all-payer system based on Medicare pricing, even one which purports to use a negotiated process, will inevitably turn into a bureaucratic nightmare of rigidity and rationing.

Now, the business community generally supports what were called incentives and competition approach to ensure universal financial access to appropriate health care, and we think we can set some achievable access goals to reduce the number of uninsured by maybe two-thirds to three-quarters over the next 5 years through a combination of public and private actions that are laid out in our testimony.

We also believe that we have to reform and fully fund Medicaid so that individuals below the poverty level have insurance protection.

We must ensure that health insurance coverage is available for small businesses, and there need to be addressed a whole battery of cost containment initiatives. In that regard, while they are mentioned in specificity in the statement, I think what HealthAmerica really needs and where the whole debate needs to go, where it needs to be joined one more time, to take it where we have to go, is to really think through the information technology connection to the issue because you can't do a lot of the things that you want to do unless you put together an information network that allows everyone to understand what's going on, what the costs are, who is doing what procedures, to whom, with what results, in common language that everyone has access to.

Now, the *New England Journal of Medicine* had an article in May which suggested that perhaps $100 billion was unnecessarily trapped in an outmoded paper-based administrative system, and in May also, the *New York Times* had an op ed piece authored by Joe Califano entitled, "More Health Care for Less Money." I think if you think about the dramatic kinds of benefits you could get by integrating information technologies into the whole system, you can find the $30 billion you are looking for in access if people like Secretary Califano and the *New England Journal* authors are suggesting there is $50–$100 billion lost in paper work just be networking through the right kind of computer connection.

Now, you cite the Rand Corporation studies that Jerry Jasinowski referred to, and you really can't in my mind access the data to make sure the practice guidelines are being followed or the appropriate managed care is being effectively evaluated unless you connect these data together.

We all understand we can fly into any airport in the country and put a credit card into a machine and get $100 cash out of our bank account, but if something terrible were to happen in a strange city, there is no way for the medical staff to access your medical records, know what prescriptions you are on, to know how to treat you. And there is no reason why, if you can't keep track of a person's finances, you can't keep track of total health practices, procedures, and input on an individual.

So we think that the debate needs to pick up the establishment of a computerized medical records system, a patient medical records system, because after all, you can't have a Federal Health Care Expenditure Board collecting data from 1,200 or 1,500 different sources, as you mentioned, without making sure it is all in one common language so they can appropriately identify what they are dealing with.

Fortunately, the Institute of Medicine of the National Academy of Sciences will release a report in September concerning the essential nature of the computer-based patient record, with the widespread hope that this can ultimately introduce more science into the practice. The age of assessment and accountability will really begin, and we won't be able to go back to the old paper-shuffling routine. It is no longer the days of the past when we went to one doctor our whole life who had our medical record in his illegible

handwriting that only he or she could read, to find out what your previous history was. Now we all go to multiple doctors who don't have the slightest idea what someone else has done to us, and until you can integrate within the system the ability to do that, I think you are going to have a hard time achieving the broader goals.

Let me also say that technology in the broadest sense is starting to bring astounding results. In the Boston area, there are some hospitals, using a program called "Chart-Checker". If you are not aware of it, you should look into it. It is a voice-activated program where emergency room doctors double check what they have done against a computer that talks back to them, and the computer makes sure they don't make mistakes. And the insurance companies that are insuring the doctors in that hospital have reduced malpractice premiums by 20 percent just by bringing in this one software package.

So there is a way to even start reducing liability costs by making sure the right kind of information is available to the people doing the treatment at the right time.

So I want to conclude my oral comments just be emphasizing this point, that there seems to be an inevitability of the way information technology is taking over the lives of the private sector, and the health care system has brought on high-tech diagnostic tools, but it really hasn't integrated high-tech information systems in a way to benefit everyone, and we think it should go in that direction next. Thank you.

[The prepared statement of Mr. Joseph follows:]

Prepared Statement of Mr. Joseph

Mr. Chairman and members of the Subcommittee, my name is Jeffrey H. Joseph. I am Vice President for Domestic Policy of the U.S. Chamber of Commerce and am accompanied by Lisa Sprague, Manager of Employee Benefits Policy for the Chamber.

The Chamber has called for health care reform for more than two decades. In 1971, the Chamber conducted a nationwide health care referendum among its members, who voted overwhelmingly in support of major reform. At that time, business was spending approximately $12 billion per year to finance group health benefits for employees. Today, that figure has grown to more than $145 billion. General inflation accounts for only $24.6 billion of that increase.

Clearly, the business community does not want to maintain the status for health care. While we should set longer-range goals, there are steps that can be taken now to address the interrelated problems of cost and access. Let me start with a few words about these problems, which seem to be worsening. Employer health benefit cost increases averaged about 10 percent per year from 1980 through 1986, and then jumped to 15–20 percent per year beginning in 1987. At the same time, the number of insured was diminishing. The percentage of uninsured and underinsured has increased throughout the 1980's—in part as a result of the cost pressures afflicting both private and public payors.

In examining the access problem, two elements should be emphasized. First, the larger part of the uninsured problem—two-thirds of it—can be traced to a lack of insurance coverage for workers and their dependents. The statistics further demonstrate that most of the employed uninsured work in small businesses. A 1989 survey of insurance coverage by firm size by the Health Insurance Association of America found that more than 94 percent of all firms employing more than 25 employees offer coverage; 39 percent of smaller firms offer coverage. Because of the very large number of smaller firms in our economy, 57 percent of all companies do not offer coverage. This is a key fact that should be remembered by those who think the access problem can be solved simply by mandating employer coverage: they are talking about mandating a benefit that more than half of all firms do not now provide.

Are there a large number of small businesses that have the financial wherewithal to provide health benefits and are simply refusing to do so? Clearly this is not the case. Small businesses, almost by definition, face significant obstacles to providing coverage. A Small Business Administration survey of companies which did not offer health insurance showed that firm owners ranked lack of profitability as the primary factor in their failure to buy health insurance. Insurance expense was the next highest-ranking factor. Small businesses face higher administrative costs, limited access to managed care plans, inability to purchase basic coverage in many states because of benefit mandates, and a limited tax deduction for self-employed small business owners.

The second key fact which must be stressed regarding access is that lack of insurance coverage among workers is strongly correlated to low wage levels—an estimated 63 percent of the employed uninsured earn less than $10,000 annually, according to one analysis of the 1988 Current Population Survey data. Looking at the entire uninsured population, nearly two-thirds lived in families with a total annual income of less than $20,000.

To be sure, there are insurance access issues among middle-income families and larger businesses, but a clear view of the problem reveals that it is principally a low-income and a small-business problem.

Examination of the cost issue reveals several key contributing factors. Of the elements that contributed to the 22 percent increase in indemnity insurance rates in 1990, price inflation accounted for the largest slice—41 percent of the increase—followed by government cost-shifting (27 percent), utilization increases (14 percent), and the introduction of new diagnostic and treatment technology (14 percent). Any effective cost containment program must decrease the pressures in all four areas.

So what can be done to solve these problems? Fortunately, most of the major interests involved in the health care debate have come to realize what business has been saying for some time—that the cost and access problems are tightly interconnected and must be faced together. Two major schools of thought are emerging: the Mandates and Regulation Option and the Incentives and Competition Option.

The central thesis of the Mandates and Regulation Option can be summarized as follows: Mandate that all employers provide a core benefits package; expand and reform Medicaid to cover all nonworking individuals and families; and control costs through a negotiated all-payor system based upon Medicare rates and with a global budget cap.

There are several problems with this general Mandate/Regulation approach. First, on the access side, it ignores the low-income/small-business nature of much of the problem. From the employer perspective, in the words of the old Russian proverb, it feeds the horses in order to feed the sparrows—the mandate applies to all businesses, when we are in fact dealing with a small-business problem. More to the point: requiring small employers to provide inevitably expensive insurance for low-wage workers would produce serious economic effects.

Here the insurance cost issue collides with the access problem. Average employer health benefit costs are now running slightly over $3,000 per year (combining both single worker and family coverage); family coverage alone is more than $4,500 per year. Adding a $3,000 insurance plan to the salary of a $10,000 per year worker is a 30 percent—compensation increase; for a worker earning $15,000 per year, it is a 20 percent increase. Given the precarious financial condition of a great many small businesses, imagine what an increase in mandated personnel costs of 20–30 percent would do. A study by the Partnership on Health Care and Employment estimates that between 630,000 and 3.5 million workers will likely lose their jobs under the type of mandate plans being advanced on Capitol Hill.

The "pay or play" feature makes it no better, and perhaps worse. While giving a small business the opportunity to cap its health benefits costs at 7 or 8 percent of payroll, these proposals set up a dangerous potential for adverse selection against the public insurance program and for more cost-shifting to larger businesses. Any small company with other than very good health claims experience would likely exceed 7–8 percent of payroll and would probably elect the "pay" option. As the public program is increasingly selected against, Its costs would go up and it would very likely counter by reimbursing at steeply discounted rates. The result, of course, would be more cost-shifting to the remaining privately insured companies.

In addition, as concerned as companies are about health-cost increases, most are not prepared to believe that the answer lies in regulating prices and capping total expenditures under a federal program. We have all learned that when the federal government drives health policy, it becomes budget policy. An all-payor system based on Medicare pricing, even one which purports to use a negotiated process, will

inevitably turn into a bureaucratic nightmare of rigidity and rationing, and without the current cost-shift escape hatch.

The business community generally, and the Chamber specifically, support an Incentives/Competition approach to ensure universal financial access to appropriate health care. The Chamber's policy recommendations encompass a consciously incremental approach. We believe this is also a realistic approach, given political and budgetary constraints. In the current "stalemate" climate, setting out to plug each and every gap in the access problem may be counterproductive as a starting point. Our proposal has four major parts.

First, the Chamber recommendations begin with a defined, achievable access goal, set by the President and Congress, of reducing the number of uninsured in this country by two-thirds to three-quarters over the next five years through a combination of public and private actions. If we can significantly reduce the problem, then five years from now, the final gap-closing solutions may become substantively and politically more feasible. A similar goal relating to reducing health-cost inflation needs to be developed.

Second, federal and state governments must do their part by reforming and fully funding Medicaid so that all individuals below the poverty level have insurance protection. The Children's Medicaid Coalition, of which the Chamber is a member, helped to achieve a significant expansion of this program last year, and there is more to be done. For business, this is a critically important element in reducing government cost-shifting, which is estimated to account for about 27 percent of indemnity insurance cost increases.

The reformed Medicaid program should "buy-in" to employer plans wherever possible, funding the employee cost-sharing for low-wage workers on a sliding scale basis. Further, people with incomes between 100 and 150 percent of the federal poverty level should be able to purchase, for a sliding scale premium, coverage through the reformed Medicaid program.

Third, we must ensure that health insurance coverage is available for small businesses. Currently, the forces of very tough competition in the health insurance industry are driving insurance companies to stricter underwriting practices for small businesses. We must return to the traditional concept of insurance—the spreading of risk across a wide population. To achieve this goal, insurers must change their underwriting practices. Such changes should include:

—accepting all employees when providing group coverage to a company;
—guaranteeing renewal of a group at pooled rates, once the group has been accepted;
—imposing no new preexisting condition limitations on an individual who has been continuously insured when that person changes employment or coverage; and
—providing a reinsurance pooling mechanism in order to spread risks among participating insurers and HMO's.

As important as these underwriting changes are for small business, the Chamber recognizes that they are unlikely to lower the cost of insurance for most employers. The issue of affordability remains. We are currently studying with interest the recently enacted Connecticut plan which would give previously uninsured small businesses access to reduced provider-reimbursement levels for some transitional period after they purchase coverage. We also are studying various approaches to create tax incentives, perhaps limited to an employer's benefit costs for low-wage workers, as a transitional subsidy.

Fourth, we must put into place a whole battery of cost-containment initiatives, including:

—eliminating state benefit mandates;
—overriding state barriers to managed care;
—enacting medical malpractice reform;
—developing clinical practice guidelines, tied to both reimbursement and malpractice protection;
—constraining excess capital spending (e.g., inclusion of capital in diagnostic-related group (DRG) reimbursements for Medicare, along the lines being proposed by the Health Care Financing Administration);
—producing a mechanism for authorizing reimbursement for new medical technology;
—launching a major federal initiative to use managed care technology in Medicare and Medicaid; and
—establishing computerized medical records systems.

To really make all of this work, we need to bring the entire health care system into the 21st century. We should explore how new information technologies can be applied to the health care system to save budget dollars (as well as those public economic resources tied up in the health care system that do not show up in the budget process, the so-called "hidden taxes" of government) by reducing paperwork and regulatory costs. Paperwork reduction and regulatory relief has been an ongoing legislative issue for the Chamber and other diverse groups, including state and local governments. Our goal: To get a "bigger bang for the buck" by better managing our information management resources.

We have witnessed tremendous productivity gain's in the manufacturing sector as a result of the application of new information technology. The labor-intensive service sector, where productivity gains are more difficult to quantify, has been slower to adopt and integrate information management technology. There is enormous potential for savings in the health care arena. In May 1991, the *New England Journal of Medicine* ran an article which theorized that up to $100 billion was unnecessarily trapped in an outmoded, paper-based administrative system. Specifically, $30 billion already in the system could be redirected to provide health insurance coverage to those who have none.

The pace of change in information technology has been phenomenal, and the potential even more incredible. Ten years ago, when we were talking about the cost-saving potential of information management technology, most of us were using typewriters; today most of us cannot imagine life without computers.

The impact of information technology on the health system goes beyond administrative efficiency to the heart of patient care. Studies at the Rand Corporation reveal that as much as one-fourth of hospital days, one-fourth of procedures, and two-fifths of medications—may be unnecessary. Timely and secure access to information in the patient record is crucial to improving health care delivery. Unfortunately, today most of the requisite clinical information remains embedded in fragmented, paper-based, often illegible, and sometimes irretrievable patient records. Many of the advances in information and communications technologies have not been adopted for use in patient records.

The establishment of a computerized medical records system could result in the more effective delivery of care to individual patients, while increasing the ability of providers and payers to monitor and improve the quality, appropriateness, and efficiency of medical care. In addition, the clinical data pooled in regional and national databases and made available through networks would constitute a vast information resource upon which to base hearth care policy, clinical studies of effectiveness and appropriateness, equitable reimbursement policies, and scientific hypotheses for further research. The computer-based patient record in not a panacea, but it does hold immense potential to facilitate improved decision-making everywhere, from the bedside up through the formulation of national hearth policy.

The Institute of Medicine of the National Academy of Sciences is now preparing to release a report concerning the essential nature of the computer-based patient record (CPR), with the hope that widespread use of the CPR can ultimately introduce more science into every practice. The age of "assessment and accountability" has begun, and there is no turning back as many forces are now converging to accelerate the demand for substantial quantities of clinical data in machine-readable form. It is not just a good "idea; the routine use of sophisticated-clinical information systems will soon be essential to survival in this new competitive health care environment.

We also must aggressively move forward in areas previously identified as affecting health care costs. One such area is defensive medical practices, where physicians order tests and procedures that may not be medically necessary, in order to protect themselves from unwarranted malpractice suits. It is estimated that as much as $50 billion is spent on defensive medicine. Medical professional liability reform is an issue that needs no more study. The time for action is now.

Other changes can also have a dramatic impact on liability costs, including information technology. For example, in Boston several hospitals use a software program called Chart Checker, which double-checks emergency room physicians' work to ensure appropriate care was delivered. Malpractice insurers are now offering 20 percent discounts to physicians working in hospitals where this system is in place.

The Chamber also supports the development of practice guidelines, review protocols, and outcomes-based assessments through a national effort led by physicians and scientists as the key to improving quality and eliminating ineffective care. We believe development and implementation of national medical practice standards should be supported by expanded federal funding, and we are pleased this effort is now being spearheaded by the Agency for Health Care Policy and Research

(AHCPR). We believe the scope of AHCPR's work should be expanded beyond the Medicare population. Use of practice standards should be tied to protection from malpractice claims under state law.

My goal in testifying today was to raise issues the Chamber believes are important within the context of the health care debate, but currently are not being adequately addressed. If we are to achieve true reform of the system, we must focus attention on some of the underlying problems and craft targeted solutions. We must move away from the failed policies of the past two decades, which only try to identify new sources of revenue without addressing the factors fueling health cost inflation.

Thank you for this opportunity to present the Chamber's views.

The CHAIRMAN. Thank you. Dr. England.

Dr. ENGLAND. Good morning. I am Mary Jane England, president of the Washington Business Group on Health, an organization representing Fortune 500 employers. We have been in the business of looking at national health system issues since 1974.

Mr. Chairman, WBGH commends you and the members of this committee for your leadership in looking to develop national health system reform, particularly to the new bill that has been submitted.

HealthAmerica really breaks new ground. We are moving to a new and productive phase in looking at health system reform in this country. We recognize that reform must include access, cost management, and quality improvement initiatives in a single package.

At this time, the Washington Business Group on Health has not taken a formal position on the bill. We are now preparing extensive, detailed comments that will be submitted to the committee before it marks up the bill.

In the summer of 1990, the Washington Business Group on Health surveyed its members to find out its position on national health system reform. Eighty-nine percent say that limited reforms cannot fix our health system problems, that we need major reform. Of interest, if the costs continue at the rate we are going now, within the next few years, many of them feel that national health system reform is necessary.

The reason that fundamental change is needed is the cost spirals that we have seen. Business has experienced certainly many concerns around strikes, around the issue of pay increase or benefits. We are also concerned that the cost spiral in health care has handicapped other sectors of the economy, certainly in international competition and also in the areas of education.

We are very concerned about access. Our members feel that there should be universal access for all Americans. We are particularly concerned about the children in this country. There are large numbers now who are falling into poverty, and 40 percent over the last decade that no longer have health care. Thirty-four million uninsured is certainly unacceptable for all of us.

We are concerned about the quality; that our health care system in this country has insufficient attention to prevention and primary care, resulting in avoidable illnesses. We are concerned about the high level of inappropriate and unnecessary care as my colleagues have presented to you today.

We are concerned that there are different mortality and morbidity rates across providers, which is unnecessary. Quality problems

are a symptom of a fragmented delivery system that does not impose accountability.

We are here today to suggest to you that we need to have developed a new way of doing business in health care in this country. We need competing, organized systems of care to contain costs and improve quality. Our health system reform will fail unless we go to the root of our problems by restructuring the delivery system.

Corporate America's vision of what organized systems of care are is vertically integrated financing and delivery systems that use a panel of providers selected on the basis of quality and cost management criteria to furnish members with comprehensive services.

The organized systems incorporate continuous quality improvement mechanisms and incentives to ensure appropriate care and are accountable to purchasers and patients on the basis of cost, quality, and outcome data.

In greater detail, the delivery of the full spectrum of care from prevention to chronic illnesses, we need to have the continuity of care across disability, retirees, all ages, as well as our traditional health care programs. We need a limited number of organized systems of care. Patients should have meaningful choice between these systems of care, and payment should be tied to successful performance with some degree of risk-sharing. Patients will share in the costs to invest in the decisions about medical care.

WBGH supports many of HealthAmerica's concepts, while reserving judgments on its particular mechanisms. We laud you on the issue of universal insurance coverage for all Americans; the expanded funding of community health centers; the preemption of State-mandated benefits and anti managed care laws; the expanded outcomes research, practice guidelines and technology assessment to address quality and cost issues; the restructuring of Medicaid with comprehensive Federal eligibility, coverage and reimbursement standards; the reduced cost-shifting to the private sector by public sector payers—the commitment to this is very important to our members, but we are concerned about language in the bill that indicates this won't be achieved for many years.

We laud you also on the recognition of small employers' unique needs, and the encouragement—I support my colleague's recommendation—of paperless claims processing. It seems incredible to me that we can do our banking with a card, but we can't get our health care with a similar card.

Reform of the small group health insurance market. Within the Washington Business Group on Health, we are evaluating a more thorough restructuring of the small group market than the reforms specified in your bill, and we will share them with you.

We are particularly concerned about the lack of emphasis, although mentioned in your bill, of malpractice reform, and again with my colleagues, I support Senator Hatch's bill and the leadership that he has taken in this area. We need to go beyond grants to encourage State reform. Systems need fundamental change. Right now, it is inefficient and fails to compensate many injured persons, defensive medicine, and a lot of other problems caused by lack of malpractice and liability reform in this country.

Some of our companies have moved very strongly into the area of organized systems of care, and again we ask you to address this more comprehensively in your bill than is currently mentioned.

We appreciate HealthAmerica's recognition of managed care's importance, but we are concerned that some of the specific provisions will interfere with the development of effective managed care arrangements. HealthAmerica lacks positive incentives for transition to organized systems of care. Business cannot do this alone. We need help, and we need public policy incentives, and we are working on recommendations to share with you as you mark up the bill.

We also feel you need to restructure Medicare and proposed AmeriCare into organized systems of care.

The controversial issue which many of our members continue to be concerned about, which my colleagues have shared with you, is the whole area of "pay or play". Some of the Washington Business Group on Health members support this; others are critical. Our ultimate position on this issue will be heavily influenced by the specific treatment of a number of issues in the bill, as whether it is tied to effective cost management and quality improvement strategies. "Pay or play" will not work unless it is actually implemented with organized systems of care and a new way of doing the business of health care in this country.

The whole area of expenditure targets and negotiated rates—there is no consensus in our group on those issues as well. A minority of the Washington Business Group members favor it as a way to contain costs and address cost-shifting; a minority opposes it, concerned that it will freeze delivery systems' inefficiencies into place without containing costs. The majority is undecided and skeptical, but willing to listen to the argument of this approach with an open mind. All agree that expenditure targets/negotiated rates alone are not an adequate cost containment strategy. We need to change the delivery system. Discussion as to whether the expenditure targets/negotiated rates will foster change continues.

We thank you for the opportunity to present this to you today. We wish to work with you in the future in improving this bill that will provide universal access for all Americans. Thank you.

[The prepared statement of Dr. England follows:]

Prepared Statement of Dr. England

I. *Introduction*

Good morning. I am Mary Jane England, President of the Washington Business Group on Health (WBGH). WBGH is an organization of Fortune 500 employers that has been involved in public- and private-sector efforts to improve health care delivery and financing since 1974. I appreciate the opportunity to discuss S. 1227, HealthAmerica, with you today.

Mr. Chairman, WBGH commends you, Senators Mitchell, Riegle and Rockefeller, and all of this Committee's members for your intensive work on health system reform. Your leadership in introducing Health America has moved the national debate about health care into a new and more productive phase. In particular, HealthAmerica breaks new ground by recognizing that reform must include access, cost management and quality improvement initiatives in a single package. Several of HealthAmerica's specific proposals remain highly controversial in the business community, but its commitment to truly comprehensive reform establishes the basis for us to enter into a dialogue about the proposals.

At this time, WBGH has not taken a formal position on S. 1227. We are now preparing extensive, detailed comments that will be submitted to this Committee before it marks up the bill. These comments will be reviewed by the newly established WBGH Policy Committee and offered as constructive suggestions, independent of the position we ultimately take on HealthAmerica.

II. *The Need for Fundamental Change in the Health Care System*

In the summer of 1990, WBGH surveyed its members to determine their positions on health system reform. Fully 89 percent of the respondents said that limited reforms to the existing health care system, rather than broad system changes, could not fix the health care system's problems. Our members' sense of urgency is indicated by their attitudes toward the continuation of employment-based health care benefits. Ninety percent thought that employers should continue to be the major provider of health care benefits to their employees. However, 37 percent of these respondents stated that they would change their answer if per capita benefits costs increase at least 15 percent per year for three years, with no evidence that the rate of increase is slowing.

Our health care system's serious cost, access and quality problems form the basis for WBGH members' support for fundamental reforms.

A. *Costs*

The United States spends much more per capita on medical care than other industrialized countries. Cost trends are even more disturbing than the high absolute level of medical costs. Between 1970 and 1989, per capita medical expenditures grew at 4.9 percent per year. U.S. medical spending would be justifiable if it bought better outcomes than are achieved in other countries; or if outcomes improved as fast as costs increased. Unfortunately, there is not much evidence that we are getting our money's worth.

The medical care cost spiral causes significant problems for American businesses, which lowers all Americans' standard of living. These problems are manifested in at least four ways:

—Medical insurance benefits have become a highly contentious labor issue. By some accounts, disputes about insurance benefits have become the leading cause of strikes. Strikes mean lost production and lost wages.

—The increasing proportion of federal and local revenue being spent on medical care leaves less for investment for other social needs, such as education and transportation networks. ass investment in these areas means less productivity and thus a lower standard of living.

—For at least some sectors of the economy, high and rapidly increasing medical care costs are a handicap in international competition.

—Massive annual health care cost increases have to be paid for by giving up something else. Employers must reduce other costs, such as investment in research and capital; increase prices; or pay lower wages than they would otherwise pay.

B. *Access*

Although the United States spends more than any other country on health care, approximately 34 million Americans are uninsured. A number of studies show that being uninsured not only means receiving fewer health services; it also results in higher rates of illness and death. Sadly, children have been especially victimized by the growth in the number of uninsured persons—between 1977 and 1987, the proportion of children without health insurance grew by 40 percent. This was the result of lower rates of coverage through both public programs and the workplace. Clearly, cost increases have played a role in producing this result.

Traditional gap fillers for persons without insurance have also deteriorated. For example, budget cuts and rising malpractice costs have reduced Community Health Centers' capacity to serve uninsured persons. In major urban areas, hospitals have been forced to close their emergency rooms. State and local health department clinics have also faced cutbacks.

C. *Quality*

Our medical care system is afflicted with serious quality problems. We pay insufficient attention to preventive and prima care, resulting in avoidable illnesses. We continue to permit, and pay for, high levels of inappropriate and unnecessary care—for some procedures, an estimated one-third are inappropriate. This is not a case of more equals better Inappropriate and unnecessary procedures cause death, illness, pain and lost productivity. Large, medically unjustifiable differences in the rates at which procedures are performed in different areas persist, even though we've known about the phenomenon for years. Different providers' patients die at marked-

ly different rates—one recent study found a 100 percent variation in death rates among 42 hospital intensive care units. Providers' impact on their patients' functional status is probably equally variable. Finally, we do not even do a very good job at keeping medical records—the basis for achieving quality improvements. A study of patients who underwent one type of spinal surgery at six Vermont hospitals found that each of four data elements critical to patient care was missing from between 20 percent and 50 percent of their charts.

Our quality problems, like much of the cost problem, are symptoms of the fragmented way health care is organized. Most care is delivered on a piece work basis. Providers operate independently, without accountability for results or cost. While some believe current utilization review performs this role, often it simply attempts to "inspect in" quality. The multitude of specialists who treat a seriously ill person are often poorly coordinated. Incentives to improve quality and manage costs are few and far between. Even those providers who want to perform these roles for their patients usually lack the tools to do so.

III. *WBGH Supports Many of HealthAmerica's Concepts*

WBGH supports many of the concepts included in HealthAmerica, although I must emphasize that our ultimate position will be determined by how these concepts would be applied in practice. While we reserve judgment on the particular mechanisms specified in S. 1227, the concepts we support include the following:

—Universal insurance coverage for Americans.
—Expanded funding for Community Health Centers.
—Preemption of state mandated benefits and anti-managed care laws.
—Expanded outcomes research, practice guidelines, and technology assessment to address quality and cost issues.
—Collection and dissemination to purchasers of cost and quality data on providers.
—Restructurmg of Medicaid, with comprehensive federal eligibility, coverage and reimbursement standards.
—Reduced cost-shifting to the private sector by public sector payers. While WBGH believes that this commitment to reduce the major source of cost-shifting is vitally important, we are uncomfortable with the suggestion in S. 1227's current language that this goal will not be realized for many years. We also believe that cost-shifting methods other than low reimbursement rates, such as Medicare secondary payer rules and COBRA, should be addressed in the context of comprehensive health system reform.
—Reform of the small group health insurance market. Within WBGH, we are now evaluating a more thorough restructuring of the small group market than the reforms specified in S. 1227.
—Recognition of small employers' unique needs, through a set of incentives for them to purchase insurance. However, we are concerned about incentives that promote cost-shifting.
—Encouragement of paperless claims processing.
—Medical malpractice reform. Even before we submit our comments for mark-up, though, I can say that Congress needs to do more than simply give states grants to reform their malpractice systems. Our current system (1) spends one dollar to provide 38 cents of compensation, (2) fails to compensate many injured persons, (3) contributes to rising health costs through defensive medicine and rapidly increasing malpractice premiums, and (4) causes problems with access to services such as obstetrics. It needs fundamental reforms now.

IV. *HealthAmerica and WBGH's Vision of Organized Systems of Care*

A. *Organized Systems of Care*

WBGH believes that radical change of our fragmented medical care delivery system is needed to contain costs and improve quality. Any health system reform legislation that is adopted will fail unless this step is taken. Severe cost and quality problems will persist, even if the access problem is temporarily "solved."

While our vision of a changed delivery system remains under development, in numerous discussions with WBGH's corporate members its parameters have begun to take shape. In our view, the vast majority of Americans should receive their medical care through competing "organized systems of care." In our working definition of this concept, organized systems of care are vertically integrated financing and delivery systems that use a panel of providers selected on the basis of quality and cost-management criteria to furnish members with comprehensive services. The organized systems incorporate continuous quality improvement mechanisms and incentives to provide only appropriate and necessary care into their operations and are

accountable to purchasers and patients on the basis of cost, quality and outcomes data. In greater detail, the key elements of the reformed delivery system include the following:

—Organized systems of care will deliver the full spectrum of medical services, preventive and primary care through tertiary and chronic care. Since the system as a whole will be at least partly at risk for the cost of care, this will limit cost-shifting between different types of services (e.g., inpatient to outpatient).
—Services will be provided by selected health care professionals and selected hospitals willing and able to meet the systems' quality and cost-management criteria. The system will directly own some of the facilities that provide care. Other sites, such as centers of excellence for specific procedures will be managed contractually.
—In any given region, a limited number of these vertically integrated organized systems of care will replace the current multitude of players.
—Organized systems of care will be evaluated on the basis of such factors as conformity to the standards of necessity and appropriateness from studies in the medical literature, improved patient outcomes and consumer satisfaction with treatment. Payment will be tied to successful performance, with some degree of risk-sharing with providers. Patients will also share in the cost of care, in order to give them a stake in decisions about their medical care.
—Organized systems of care will incorporate in-house quality improvement and peer review mechanisms, based on widely available medical protocols and outcome measures. The system will have built-in incentives to treat patients appropriately.
—The collection, analysis and use of data within the system will facilitate monitoring of cost, quality and outcomes. This information will be made available in usable formats to purchasers, patients and public entities. Purchasers will move away from micro-managing numerous medical transactions to monitoring the performance of a few systems. Patients will be given the information needed to take responsibility for their own medical
—Benefits will undergo some standardization, promoting competition based on value and quality.
—Patients' choices of providers will be limited by the unavailability of reimbursement for services obtained outside the organized system they join. Patients will be able to choose among providers within their system. Moreover, patients will be given a meaningful choice between competing organized systems of care.
—The organized system of care, in partnership with its individual providers, will be responsible for quality. Therefore, the system itself will be liable for malpractice.

B. *Organized Systems of Care in Relation to Managed Care*

It is important to recognize the fundamental difference between WBGH's vision of organized systems of care and many current managed care arrangements. Managed care is an important improvement upon traditional arrangements which incorporated no cost or quality controls on the provision of health care. But, as currently practiced, the first generation of managed care (1) is often insufficiently selective in structuring provider networks and allows too many opportunities for patients to leave the network, (2) often builds on inherently inefficient fee-for-service reimbursement, and (3) is oriented more toward procedure-specific utilization review than quality improvement mechanisms and accountability for overall performance. Further, with only a small portion of the population in real managed care plans (as opposed to "managed indemnity" plans) there are too many opportunities for cost-shifting and shadow-pricing. These factors explain why many studies indicate that managed care has only a limited impact on cost.

WBGH's goal is not merely to intensify current managed care practices, but to structure a different way of delivering care. We believe that enrollment of virtually the entire population in a limited number of competing, vertically-integrated networks of selected providers will achieve the cost savings that have eluded managed care. Evidence to support this view comes from a number of large companies and purchasing groups of small employers that have implemented the programs that most closely resemble WBGH's concept. These companies and purchasing groups are providing the laboratory for early experiments on the organized systems of care concept. Since these plans do not enroll a large percentage of the total population, and none yet employs all of the organized system of care elements discussed above, the results are not yet conclusive. Nonetheless, these plans' experiences indicate the potential for organized systems of care to serve employees in businesses of sizes. For

example, Southwestern Bell, Honeywell and Southern California Edison have all used several elements of the organized systems of care strategy to hold their annual cost increases to levels well below the national average. Kaiser-Permanente has done the same for its subscribers. Many of the smaller and mid-sized businesses that WBGH works with through its National Business Coalition Forum on Health have formed purchasing groups to pursue elements of organized systems of care. Favorable cost results have been achieved even though most purchasers have not taken the steps necessary to organize an efficient delivery system. The full potential of organized systems of care will be realized only when most purchasers do so, thereby giving providers and insurers a consistent set of incentives to operate efficiently.

It is important to emphasize that these state of the art programs are not designed solely to achieve cost savings. They also promote quality care and provider accountability. For example, Honeywell and Xerox have worked very closely with their provider networks to encourage the development of standards of care and methods to monitor provider performance. Digital Equipment Corporation has set up intensive procedures to monitor its HMO's abilities to meet quality of care and cost containment objectives. Digital and 11 other Companies are also part of the Outcomes Management System project. Sponsored by InterStudy, the project is linking patient assessment and outcomes information for three conditions. This information will be used to select provider networks and monitor ongoing performance. These corporations recognize that there is no such thing as inexpensive low quality care. By promoting quality, they expect to achieve healthier workers and lower medical costs.

C. *Organized Systems of Care and HealthAmerica*

WBGH recognizes that HealthAmerica was drafted with the intent of making accommodations with what it defines as managed care. While we appreciate this recognition of the contribution that managed care can make, our preliminary analysis suggests that HealthAmerica does not go far enough in this direction. For example. capping cost-sharing while barring employers from offering only closed panel networks creates a disincentive to effective managed care arrangements. Ironically, this disincentive operates most strongly in the case of high cost persons who generate the bulk of health care costs and who have the most to gain from quality-oriented managed care.

In addition, HealthAmerica does not include the positive incentives needed to accomplish the transition from fragmented fee-for-service medicine to efficient organized systems of care. The logic of the market is driving many purchasers to institute key elements of organized systems of care. Despite this progress, I cannot tell you that individual corporations acting on their own can cure the ills of our country's medical care system. WBGH recognizes the need for public policies which will speed the movement of providers, purchasers and patients into organized systems of care. WBGH is now reviewing a number of public policy options and will issue its recommendations later this year.

One policy that I am prepared to recommend at this time is the restructuring of federally funded medical care programs. As the nation's single largest purchaser of care, Medicare can exert great influence over how medicine is practiced in the United States. HealthAmerica should restructure Medicare so that it provides care to beneficiaries through a limited number of competing, organized systems of care. AmeriCare should be treated in the same fashion.

V. *"Play or Pay." Expenditure Targets and Negotiated Rates*

Both the "play or pay" approach to expanding access and expenditure targets/negotiated rates as a cost containment strategy remain controversial in the business community. At the present time, some WBGH members are supportive of the play or pay concept, while others are critical of it. Clearly, WBGH's ultimate position on play or pay will be heavily influenced by the specific way in which it would be implemented, and by whether it would be tied to effective cost management and quality improvement strategies. I expect that the comments we will submit prior to S. 1227's mark-up will address in detail such specifics of its play or pay plan as the basis for calculating the pay option's cost, how dependent coverage costs are distributed, and how part-time and temporary workers are treated.

WBGH's members have not yet reached a consensus concerning expenditure targets/negotiated rates. Currently, a minority of our members clearly favor some form expenditure targets/negotiated rates. They believe they are an effective means of containing costs, and of addressing cost-shifting from the public sector to the private sector and within the private sector. Another minority clearly opposes expenditure targets/negotiated rates, based in part on the view that they will freeze the current delivery system's inefficiencies in place without providing meaningful cost relief. Perhaps the best way to characterize the majority of WBGH's members is as "unde-

cided and skeptical, but willing to listen to the case for expenditure targets/negotiated rates with an open mind." These members believe that data from all-payer rate-setting states and Canada does not prove the argument that negotiated rates will contain costs.

Overall, I believe that all of our members would agree that expenditure targets/negotiated rates alone do not constitute an adequate cost containment strategy, and that these mechanisms must foster rather than inhibit the transition from fragmented, fee-for-service medicine to organized systems of care. Whether the latter goal can be achieved remains a topic of discussion within WBGH.

Up to this point, I have been discussing expenditure targets/negotiated rates in principle, rather than the specific measures provided for in S. 1227. While I will leave detailed comments to a later date, at this time I will note that even among some supporters of this approach there is discomfort that S. 1227's mechanisms do not have enough teeth.

Mr. Chairman, I will close my testimony today by again noting WBGH's appreciation for the commitment to comprehensive health system reform which is found throughout S. 1227. WBGH looks forward to a continued dialogue about this vital initiative.

The CHAIRMAN. Thank you very much.

Senator THURMOND. Mr. Chairman.

The CHAIRMAN. The Senator from South Carolina.

Senator THURMOND. I would ask unanimous consent that my statement appear in the record as the ranking member. I am at another committee meeting, and I have four questions here, and if this first panel could answer those for the record, I would appreciate it.

The CHAIRMAN. Your statement will be included in the record in its entirety.

[The prepared statement of Senator Thurmond follows:]

PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman: It is a pleasure to be here this morning as we continue our hearings on health care reform legislation. As we hear from the Chamber of Commerce, the American Medical Association, and others, I think it is important for us to keep in mind what this Nation spends on health care. In 1990 alone, $666 billion was spent on health care. As many are aware, this represented 12.2 percent of the Gross National Product (GNP). When compared to a 5.3 percent rate in 1960, we get a vivid picture of just how sharp the rise in health care costs has been.

Now, the real question is—what is the proper role for the Federal government in addressing these cost concerns? At the present time, there does not appear to be a clear consensus on any one proposal for reform. Some advocate more Federal involvement, while others recommend a market-oriented approach using various incentives.

I am pleased, however, that this Committee is continuing to move forward, even though we may have different opinions on the proper means for achieving health care reform.

I look forward to hearing from each of the witnesses.

Senator ADAMS. Mr. Chairman, may I also ask that my statement appear in the record in full.

The CHAIRMAN. Yes, your statement will be included in the record.

[The prepared statement of Senator Adams follows:]

PREPARED STATEMENT OF SENATOR ADAMS

Mr. Chairman, I want to thank you for holding this hearing today so that we might hear the views of a broad range of organizations on the HealthAmerica plan. This is not the first time we have heard from many of today's witnesses on how to meet the health care crisis we face in this country. Nor is it the first time we have heard the truly staggering statistics of the number of Americans who have no health insurance in this country or who are underinsured. I am concerned, however, that we not become so familiar with this number that we become complacent and fail to be shocked by the fact that 37 million Americans have no health insurance and 60 million Americans have inadequate health insurance.

I know we will hear a variety of opinions today about the HealthAmerica plan today. Some favorable, some not. Sen. Kennedy has done a remarkable job on this bill and it reflects his firm commitment to get a bill out of this Committee that will have a chance of being enacted.

As Sen. Kennedy knows, I am very concerned, as he is, about skyrocketing health care costs. I am particularly concerned about the growing practice of physicians who refer patients to medical or laboratory facilities in which they have a financial interest. This practice has led to some patients receiving almost twice the number of services, costing the government millions of dollars.

On Monday, the Office of the Inspector General at HHS issued final regulations on the Medicare-Medicaid Anti-Kickback Statute. The IG has been looking into physician referral practices over the last several years and found that such practices has led to serious abuses.

I am concerned that these new rules may not achieve their desired effect. First, they are limited only to referral practices that receive federal reimbursement; and second, they may end some abusive practices while permitting other referral practices to continue. The Office of the Inspector General, in explaining the new rule suggests as much: "The final rule . . . by specifying various payment practices which, although potentially capable of inducing referrals of business under Medicare or a State health care program, will be protected from criminal prosecution or civil sanctions under the anti-kickback provisions of the statute."

What the rules do is to carve out "safe harbors" for certain physician self-referral practices, providing some physicians with a financial interest in a medical facility immunity from prosecution for practices which the IG has found led to patients receiving unnecessary services, and which have increased the costs of some health care services as much as four fold.

Desiginating safe harbors for these type of medical practices may not be the best public policy. Instead, we should be designing public health policy that eliminates physician self-referral altogether. It is an important way to contain costs and eliminate unnecessary care. I plan to bring such a bill before this Committee.

I look forward to the testimony of today's witnesses.

The CHAIRMAN. I'll take 6 minutes for the first round, since other members are here, and I'll ask the clerk to watch the time.

Listening to the testimony this morning, one of the striking aspects is the change in both the tone and the recommendations of those appearing on this panel and I expect later panels as well. It appears that for the first time there is general recognition that we have to have an alteration or a change in the system. What we have not been able to achieve is what that change should be and how it should be implemented. But I think there is an important recognition that there has to be some significant alteration and change.

I was struck, Mr. Jasinowski, with your testimony. Based on what you have said today, the impression is that business has come a long way in the last few years in terms of the proposals it is willing to consider and in the priority it places on the health care issue generally. Is that a fair assessment?

Mr. JASINOWSKI. I think that is right, Senator, and I think it is because the health care costs are rising more rapidly than any other single cost, depriving us of resources for everything else in the corporation.

The CHAIRMAN. And as I understand, your general position is for universal coverage and effective cost containment.

Mr. JASINOWSKI. That is certainly the case, although again I would put much more emphasis on the quality aspect of the cost containment. Cost containment is a very limited concept, and quality is a whole point of view which really has to be accepted in the health care system if we are going to make progress in reducing cost. So the quality word is almost a religion, Senator, in terms of manufacturing today, and we are here to say that if it becomes that in terms of this legislation and everything else, then we are satisfied.

The CHAIRMAN. You indicated there was a division in your own organization on the "pay or play" concept. What are the pros and cons of those who either favor or differ with it?

Mr. JASINOWSKI. I think there are two big pros. One is that it tends to address some of the cost-shifting, at least in the minds of many of our members, because it forces people who are now free riders to belly up to the bar and to participate. The second pro aspect is that it moves more toward individual responsibility within the system again, forcing people to either pay or play.

On the negative side, the big concern is that this is not something that small manufacturers can afford and that you are really just going to impose costs which are too onerous; and second, that the system has not been well thought through—a good idea, headed in a good direction, but it really has not advanced to a sophisticated level yet.

What do I mean? It has been underpriced in terms of what would be required in coverage. The minimum benefit package is interesting, but there are problems with how it would be implemented. Its relationship to the States, to the expenditure targets—all those things are aspects that have not been well enough thought through. And then, if you get a lot of people coming into the government system because the private sector decides it is a better deal, is the government system prepared to take them on in a way that keeps costs from escalating?

The CHAIRMAN. Well, as you point out, the reason it is underpriced is to try and provide some help and assistance to those companies and corporations that have low-income workers. We did not put into the bill the percent in terms of the payroll, but contribution building on the Pepper Commission, 7 percent has been talked about. You can ratchet that up or lower it, depending on what you want as a matter of public policy to be the public contribution and the assistance to small business.

Mr. JASINOWSKI. Well, I think that that is right, Senator, and if you ratchet it up it becomes more expensive for the firm. It is just that we ought not to kid ourselves that by picking 7 percent we are going to be able to cover the cost. The average cost for a $20,000 family is between $2,500 and $3,000 a year in terms of health care, and that is something more in the range of 12 to 13 percent. So we can't go into this thing thinking we're going to get a great bargain at 7 percent if we aren't.

You are absolutely right that if you raise it, your raise the costs. So what do you do? I don't know the answer to that. I think that as it stands, by putting this in, you are going to reduce employment among small firms.

So I don't have the answer as to how it has to be designed. I'm just saying the "pay or play" thing has some negatives, as I have indicated, which have to be thought through more carefully. We're not saying that we oppose this concept.

The CHAIRMAN. I understand. Have you done a projection of what your members are going to pay if we do nothing at all for the next 5 years, 7 years?

Mr. JASINOWSKI. Well, I think that the projections that we put out in a macro sense—and I don't have those numbers in front of me—but those macro projections of the 20 to 25 percent a year and the overall percentage of GNP are what we expect our members to pay unless we do something. Now, when we say "do something", we think that at least half of this problem can be solved in the private sector. As good as this legislation is in terms of moving forward, we are going to make enormous progress if we get providers and users moving on the quality front, the managed care, and all that. So we have to look at this as a partnership. What we're saying is we can't do it alone; therefore some kind of legislative changes, including some of the provisions here, need to be enacted to support what we are trying to do at the private sector.

The CHAIRMAN. Well, the idea of partnership is one that we certainly support, and we had hoped that with some of the observations on quality and cost control measures that you had mentioned earlier, plus a real cost containment efforts in terms of negotiation between providers and consumers and including the private sector and insurance companies in these instances, that we might be able to achieve some of those objectives. My time is up. Senator Hatch.

Senator HATCH. Thank you, Senator Kennedy.

What do you the three of you think with regard to the rate regulation approaches of the AmeriCare bill?

Mr. JASINOWSKI. Are you talking about the implications of the expenditure target, Senator Hatch?

Senator HATCH. Yes, national expenditure targets.

Mr. JASINOWSKI. Well, I think we have doubts about its ability to work; how do you set this target once the target has been set; how do you get agreement that it is going to be met. I think it is an interesting idea, as I say in my testimony. I remember in the Carter Administration the implementation of wage and price controls, and I remember in the Nixon Administration where similar things were tried.

You can argue that we don't have an adequate market system here, and we want some of that, but the problem is with DRG's and everything else, it never quite works out the way you think it will, because we aren't smart enough. So we have some reservations about the ability of the Federal Government to control all these rates.

Senator HATCH. Dr. England.

Dr. ENGLAND. The experiments that we have seen in the States have not been as satisfactory as some of us expected, and we have not seen the kind of savings in Canada that some of us would like to have seen.

I think we need to examine very carefully the whole area of rate-setting, and we are particularly concerned at the Washington Business Group on Health on the whole area of competing organized systems of care and what that would do if there were rate-setting.

So I think that certainly our members continue to be skeptical about how much that would actually be able to be helpful, although some of our members are anxious to control the cost-shifting and feel this might be a way that could actually control cost-shifting.

Senator HATCH. Mr. Joseph.

Mr. JOSEPH. And similarly, I think it is important to point out that the whole concept goes against common sense or self-interest. I mean, we can try to manage health care from a budgetary standpoint, but the average individual is not necessarily going to stop pursuing additional treatment if an artificial or maybe a real dollar target has been made, but they are dissatisfied with the way they feel, and they continue to get more money out of the system.

Senator HATCH. It seems to me we have never seen in this country a rate regulation approach really work, and I am concerned about that. I am also concerned about a number of other aspects.

Is it true in your experience with your memberships that those few or many—I suspect few—who support the "pay or play" system are basically the larger companies?

Mr. JASINOWSKI. I think that's clearly true. The NAM membership has really got about 9,000 small companies and 2,000 or 3,000 large and medium, and it is clear that the larger firms support it because it doesn't affect them. More of them support it because it doesn't affect them.

Senator HATCH. Well, they benefit by it because their rates should come down.

Mr. JASINOWSKI. It is the small companies that really are going to have the big effect here, and that is where our greatest concern comes from.

Senator HATCH. Would you find, Jerry, that most of the small companies would oppose the "pay or play" system plus the rate regulation system?

Mr. JASINOWSKI. So far, I'd have to say the majority of our small companies would oppose it as they understand it now, yes.

Senator HATCH. I don't know of one below a certain moderate size that wouldn't oppose it, to be honest with you.

Mr. JASINOWSKI. Well, we find a few who do, but certainly the majority—maybe even more than a few. I don't want to make it sound like all small firms are opposed to it, Senator. I do think that the majority clearly are opposed, and I know the small business organizations with which we work closely feel very negative about these——

Senator HATCH. But those who are not opposed are generally those who are going to opt for the 7 percent payoff.

Mr. JASINOWSKI. I think that's right.

Senator HATCH. And they can afford that because that's less than going out and buying insurance for their members.

Mr. JASINOWSKI. I think that's right, and I think that, going back to Senator Kennedy's point, there is a great deal of appeal to this proposal from some business perspectives in that maybe we can get out of the weight of this by going for this cheaper Federal program. And that would be fine if we had the inefficiencies, and if the Federal system would really work that well. But I think that we believe it won't work that well, and we'll end up with cost escalation in the Federal program being much more expensive than the projections show here.

Senator HATCH. Well, it is apparent that the 7 percent is not going to provide the full cost of the insurance or the full cost of medical care for those who opt into that program, so that money has to come from somewhere. Where is it going to come from?

Mr. JASINOWSKI. Well, that is our concern, really, with respect to the cost of this program.

Senator HATCH. Well, it is estimated that if you put a break even at about $20,000 salary, that 60 percent of all employees are going to go into a Federal welfare medical program.

Mr. JASINOWSKI. Yes, and I think again going back, in terms of thinking this through carefully, as you all recall, we went through some changes to Social Security over a decade ago that were supposed to be modest in cost, and those Social Security changes ended up being one of our largest budget difficulties in the 1980's and 1990's. We really need to look carefully at the costs here. We don't pretend we've got the answers to how much it costs. A lot of it depends upon how good the quality and cost improvements are, but the bill merits very careful additional analysis and scrutiny on that score.

Senator HATCH. Mr. Joseph and Dr. England, do you fairly well agree with these comments that have been made with regard to size of companies and so forth?

Dr. ENGLAND. I think big business is not necessarily all supportive of "pay or play", no——

Senator HATCH. No, I didn't mean to imply that, but the ones who are in favor are generally large businesses.

Dr. ENGLAND [continuing]. Because I think large business is very concerned about their suppliers, who are the small businesses, and they are very concerned about the impact on them. So I just wanted to be clear on that.

Senator HATCH. That's a very good point, and I am glad you made it clear because I did not mean to imply that all big business is for it. But the ones who are primarily for it are big businesses who figure they are going to benefit from it.

Dr. ENGLAND. Their benefit package today is much richer than anything——

Senator HATCH. They'll benefit at the expense of the small businesses, some of whom won't even be able to make the 7 percent and will have to go out of business.

Mr. JASINOWSKI. And I think most business people, big, medium and small, also are inherently suspicious that somehow the Federal Government can't keep giving them a better deal forever without some sort of price to pay back.

Senator HATCH. I think that about sums it up, but if I could just say this, I want to compliment Senator Kennedy. His original approach was so outrageous that it caused everybody to look at this problem. [Laughter.]

The CHAIRMAN. We'll be right back there in 10 years if we don't get this one out.

Senator HATCH. That's right, and I don't want him to win on his original approach. We could get in such degradation if he did.

But to make a long story short, I think without Senator Kennedy and his leadership in raising these issues, we wouldn't be where we are today, so I want to pay that personal tribute.

I also want to compliment him for adopting many of the cost containment approaches that we've had and even in the so-called "Mitchell mandate"—I call it that—it is really from Senator Kennedy that most of the bad ideas have come through the years—no, I'm only kidding. The fact is that with this particular program, they pretty well acknowledge that there is a medical liability problem in this country. Now, they don't provide the teeth, which is why I think all three of you basically support the approach that we have been advocating. They don't quite provide the teeth to really solve this problem.

Now, Pete Domenici would, of course, like mandatory arbitration of these problems, and that would provide total teeth but it wouldn't quite give the flexibility that perhaps is needed in some of these cases.

I want to say this: I want this problem solved. I myself am willing to resolve this problem, and I just say to my colleague from Massachusetts that I respect you; I respect you the efforts that you have made; I respect the approaches that you are taking here and your open-mindedness; and I respect that you have had this excellent panel speaking for business across the board to start off here today.

I think you have approached this in a moderate and reasonable way by saying there are some good things and there are some bad things, and we'd like to work it out and get something that really does resolve these very extensive problems in our society.

I just want to say to Senator Kennedy and other members of this committee that I'm willing to help try to do that. I think there are better ways than "pay or play", but you have to give credit for at least laying it down and having the debate begin. And to the extent you folks can help us in this debate—and you can—we want

you to, and we appreciate the work that you will do. We look forward to the conclusion of your studies, Dr. England. Please tell those in the big business community that I will look very much forward to that, and I hope I will not be too critical when the time comes. Thank you for being here.

The CHAIRMAN. I thank the Senator for his kind remarks, and we look forward to working together.

Senator PELL. Thank you, Mr. Chairman.

Obviously, from the viewpoint of the economy it is better for people to stay well than to be ill, and from the viewpoint of the happiness of the individual, it is better to stay well than to be sick.

I was curious as to whether you have any statistics as to the cost-effectiveness of the wellness programs that some corporations are adopting. If you can get people to work out two or three times a week, is there any actual study that proves a relationship to reduced medical costs resulting therefrom?

Mr. JASINOWSKI. We do have some analyses that show an enormous impact on companies that have instituted large-scale wellness programs, and we'll share those with you. Interestingly, a rather well-known American businessman, Boone Pickens, has been one of the leaders in this area, and his particular company, Mesa Petroleum, has reduced its costs dramatically by a very elaborate wellness program that includes everything from nutrition to counseling to fitness facilities and so on and so forth.

We have a number of other examples. I'd like to provide those for the record if I could.

The CHAIRMAN. Please do.

Senator PELL. Thank you.

[Information on Corporate Wellness programs entitled "Firms Tout Wellness Savings" by Louise Kertesz submitted by Mr. Jasinowski follows:]

LETTER AND INFORMATION FROM MR. JASINOWSKI

NATIONAL ASSOCIATION OF MANUFACTURERS,
Washington, DC, August 19, 1991.

Honorable EDWARD M. KENNEDY
U.S. House of Representatives,
Washington, DC.

DEAR SENATOR KENNEDY: During the course of testimony before the Senate Labor and Human Resources Committee on July 31, NAM was asked to provide information on corporate wellness programs. Subsequently, Senator Thurmond submitted questions for our response. The following paragraphs respond to both requests. Also, we have attached "Buying Value in Health Care," which we earlier requested to be included with the hearing record.

Corporate Wellness Programs. Adolph Coors Brewing Company in Golden Colorado, is a pioneer in corporate wellness programs. The company, which provides health benefits to 32,000 people, pays 90 percent of health claims costs of employees and their spouses who undergo health appraisals versus 85 percent for nonparticipating employees. Its on-site breast screening program, which cost $63,628 in 1989, is considered a wise investment. Had the 200 abnormal screenings advanced to the metastatic stage, it would have generated at least $298,000 in medical claims.

Avery Corporation with 8,500 employees in Santa Ana, California offers a comprehensive selection of wellness activities including a complete blood chemistry test for workers through worksite mobile medical units. The company's innovative prenatal program uses a nationally based nursing service to identify potential high-risk pregnancies—a major health concern given past experience with two premature birth cases costing $175,000 and $250,000 respectively.

Additional information on corporate wellness programs is documented in the attached "Firms Tout Wellness Savings," taken from *Spotlight on Health Cost Management* published by NAM in 1991.

Questions from Senator Thurmond

Role of Federal Government compared to Private Sector in controlling costs. Since the federal government has authority as payor for a significant market share of health care—i.e., Medicare, Medicaid—its actions have a major impact on private sector health costs. The initiation of DRG's in 1983 and now a new physician fee schedule have great impact on what employers pay for health care. Implementation of such cost containment efforts must not be a mere cost-shift to the private sector. Thus, there must be a closer working relationship between government and business in dealing with cost control than is now the case.

Context for Addressing Long Term Care. Since long term careservices are largely custodial in nature, it may not be appropriateto include long term care with overall health care reform. The complexity of the issue in of itself and its cost also argue against addressing long term care at this time. In the context of reform, some thought should be given to breaking off long term from Medicaid, which would free up more state money for the poor uninsured.

Role of Home Health care in Controlling Costs. Studies indicate that home health care, when judiciously administered, can delay and sometimes preclude the need for more costly institutional care. While Medicare does provide certain home care benefits, it might be well to explore expanding the benefit and determine the regulatory and other barriers hampering greater use of home health care. Both from a cost and humanitarian standpoint, remaining in the community is far preferable to institutional care and an option that should be fully studied given the aging of our population.

Proposed Legislation (S. 1227) and Economic Impact on Business and Federal Government. The requirement on business to "pay-or-play" may negatively impact some small businesses who will find it financially difficult to comply with a 7 to 8 percent payroll tax. Negotiated rates through an all-payer system may actually result in employers paying more for health care than they do currently. It is apparent that the payroll tax will not be sufficient to finance the public program and new taxes will be needed—taxes that will be paid by individuals and corporations. However, the legislation's objective of universal access may, in the long run, outweigh these negative factors by reducing cost-shifting from the public sector and within the private sector.

Obviously, the cost of the public program will have a major impact on the federal government, both in terms of required revenues and improving the capacity of government to implement a massive restructuring of the current health system.

We can, however, continue to debate the pros and cons of system reform indefinitely. Meanwhile, costs will continue to devour an ever increasing portion of GNP, a burden that business cannot sustain if America is to remain competitive. The NAM is committed to working with this Committee and the rest of Congress toward solutions to this complex problem. We appreciate your continuing leadership in this regard.

Sincerely,

JERRY JASINOWSKI
President
National Association of Manufacturers

Firms tout wellness savings

by Louise Kertesz

While employers for years offered piecemeal wellness programs to help trim their health care costs, comprehensive employee health management programs are trimming large amounts of fat from some companies' health care budgets. Now, instead of just offering weight reduction and smoking cessation classes or a workplace exercise center, employers increasingly are offering workers and their families a full range of wellness activities—including health risk assessments—to reduce their need for more costly medical care. And, while many employers have not tracked the effectiveness of the wellness programs they provide, some of the companies that have are reporting impressive savings.

For example, a 1988 study by Coors Brewing Co. of Golden, Colo., showed that health insurance costs for participants in the wellness programs Coors offered were 13% less than non-participants' costs, said Mark Wright, Coors' director of health services. Coors' wellness programs saved the brewing company $3.2 million in 1988, he reported. And, a 1987 survey of wellness programs conducted by the Health Research Institute of Walnut Creek, Calif., found that employers that measured their wellness programs' savings reported a 22.3% decrease in absenteeism and a 21.7% decrease in medical care costs (BI, Feb. 16, 1987).

"There's been an increased interest from just about every employer in wellness," said Scott Ziemba, a benefit consultant in the Woodlands, Texas office of Hewitt Associates. Because other health care cost management strategies, such as hospital precertification and utilization review programs, are not curbing health care inflation, "there aren't a lot of other options," Mr. Ziemba said.

In addition, employers are emphasizing wellness programs because Americans are more health-conscious than they were 10 years ago and are "more concerned about the quality of life," said Richard Sinni, director of the health management practice at Buck Consultants Inc. in New York.

But equally important, "many mature companies have an older population," which translates into higher absenteeism and greater health care costs. Companies have found that offering wellness programs cuts absenteeism and health care costs, Mr. Sinni said. And, wellness programs are a benefit appreciated by workers, according to employers.

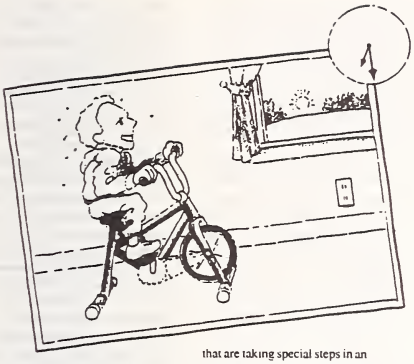
"What we've come to realize is that today's worker wants more than just a paycheck, more than just a job. They're looking for a healthy environment to work in as well," reported Cathy McComas, associate director of corporate health promotion at Texas Instruments Inc. in Dallas, which is expanding its comprehensive wellness program to sites across the United States.

The programs offered by Coors and Texas Instruments evolved from smaller ideas, such as company softball games and jogging tracks and the occasional lecture on nutrition. "Good health and well-being of Coors employees has been an important aspect of the company from the beginning. Our comprehensive recreation program began with the softball games, company picnics and other social events soon after the company started," a Coors document states.

The comprehensive wellness program at Coors evolved because Chief Executive Officer William K. Coors "was and still is the leader of the wellness movement in the company. He believes the company has a moral obligation to develop and maintain a work environment that encourages every employee to be dedicated to wellness," the document states.

Now, the Coors wellness program includes such diverse activities and options as a health hazard appraisal; medical screening for participants in physical fitness programs, including cholesterol screening, body fat measurements, education on the use of exercise equipment and treadmill screening; and blood pressure and breast cancer screening.

The Coors program also includes nutrition education; stress management; a coronary risk identification and behavior modification program; parenting skills; weight management; smoking cessation; prenatal programs; cardiac



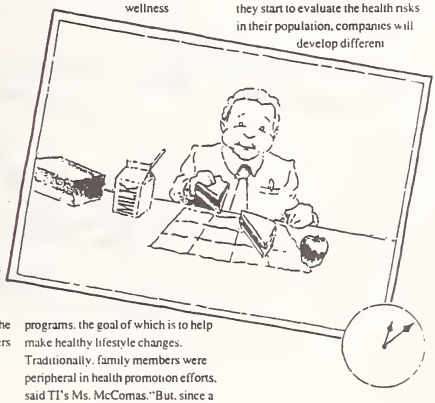
and orthopedic rehabilitation; and back care programs.

The Texas Instruments wellness program, which was introduced at one company site in January 1989 and is gradually being adopted by other sites, includes: a health assessment, including a blood test plus profiles of exercise activity, fitness and nutrition; exercise and nutrition activities; health education programs and screenings on such subjects as women's and children's health issues, aging, stress management, cholesterol control and health care consumerism; family programs publicized through motivational materials mailed to the home; and promotion of a smoke- and drug-free workplace.

To complement its wellness program, TI also has recently redesigned its health care plan to provide 100% coverage of preventive services, including cancer screening and prenatal and well-baby care, including immunizations.

Coors and TI are among the employers nationwide identified by the National Association of Manufacturers that are taking special steps in an attempt to control health care costs. Previous stories have profiled companies that have opened in-house medical clinics (BI, March 5), small employers that have taken special health care cost management strategies (BI, March 19) and joint labor- management efforts to control health care costs (BI, April 2).

Contact with the employee's family is integral to comprehensive wellness



programs, the goal of which is to help make healthy lifestyle changes. Traditionally, family members were peripheral in health promotion efforts, said TI's Ms. McComas. "But, since a lot of health care costs are incurred there, we have been searching and struggling to take a more proactive stance" in involving the family in wellness programs, she said of Texas Instruments' "Lifetrack" program.

Both TI and Coors base their programs on a thorough initial assessment of the lifestyles and health conditions of individual employees and their spouses. "You're going to be seeing more companies doing health risk assessments in 1990," said Buck's Mr. Sinni. "Everyone is trying to manage health care costs, and a lot of things in the past haven't worked. Now companies are trying to develop programs specific to their employee populations. To do that, you need an initial risk appraisal for each employee," he said.

"The two hottest areas in wellness programs are risk assessment and intervention," said Hewitt's Mr. Ziemba. "Risk assessment is low-cost but has the biggest bang," since it provides needed health information to the employee and to the company for intervention purposes, he said.

"What I foresee is that once they start to evaluate the health risks in their population, companies will develop different

The two hottest areas in wellness programs are risk assessment and intervention.

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contribution strategies depending on the risks," Mr. Sinni said, referring to the amount that employees must contribute to their health care plans. He added that several of his clients are conducting health risk assessments with such steps in mind.

Coors already is taking that approach. To persuade employees and spouses to undergo a health assessment, Coors reduces the copayment under the company's health care plan to 10% from 15% for employees who complete the assessment questionnaire and meet certain good health criteria. Those criteria are based on a measurement of their real age compared with their "health age".

Ninety-three percent of Coors' employees and spouses in the Golden, Colo., area participated in the company's health assessment program in 1988. Of those workers and spouses, 90% have lifestyle and health conditions categorized as "not at risk," based on 11 risk factors including smoking, cholesterol levels, blood pressure and seat-belt use. That is an improvement from the 72% of the 11,000 participants found not at risk in 1987.

"What that tells you is they have done something to change their lifestyles," observed Coors' Mr. Wright. Those changes have been made possible by the company's comprehensive wellness program conducted at or monitored through an on-site wellness center, where in-house professional staff and equipment purchased by Coors reduce the cost of outside testing and services.

Coors workers and retirees, their spouses and their dependents aged 12 years and older may use most of the wellness activities offered by the company free of charge. And while some services require an employee contribution—for example, mammography screenings cost $5—this cost is much less than it would cost employees on their own.

After initial screenings, participants in the various wellness programs are offered services and monitoring programs in areas such as nutrition, exercise, stress management and rehabilitation.

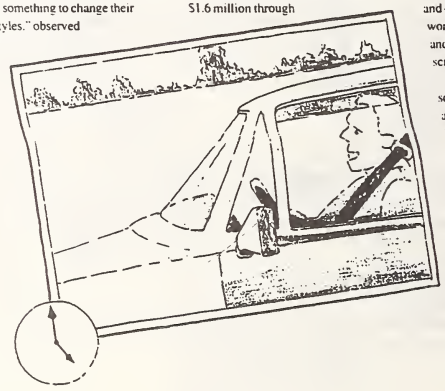
The biggest savings from Coors' wellness programs have been generated by the company's cardiac rehabilitation program, according to Mr. Wright. "In the first six years of that program, Coors' savings (from the cardiac program) have exceeded $1.6 million through wage savings and reduced program and exercise test costs," according to a Coors document. Mammography screening resulting in early cancer detection, a well-back program and an orthopedic rehabilitation program also have significantly contained health care costs, Mr. Wright said.

Coors determines the cost-effectiveness of its wellness programs in various ways. For example, for the Cardiac rehabilitation program, Coors determines "what it costs to do it in a hospital setting, as opposed to our wellness center." That includes the cost of in-house vs. outside treadmill testing. The average time lost from work due to a cardiac event also is calculated, as well as the cost of replacing an employee and training a replacement worker, Mr. Wright said.

Approximately 225 employees have participated in the cardiac rehabilitation program since its inception in 1981. "To date, 98% of these employees have returned to work, all of them to the job held prior to the cardiac event," Coors said.

Through an on-site breast screening program begun in 1985, Coors has screened more than 2,300 women: 71% of all eligible employees and 40% of spouses. Eligible women included those aged 35 and older, not pregnant and not screened in the past year.

More than 200 abnormal screenings have been recorded and four early malignancies have been detected. While the program costs have amounted to $63,628, "estimated costs to Coors if these cancers had advanced to the metastatic disease would have been $298,000" based on "direct medical costs, short-term disability costs and



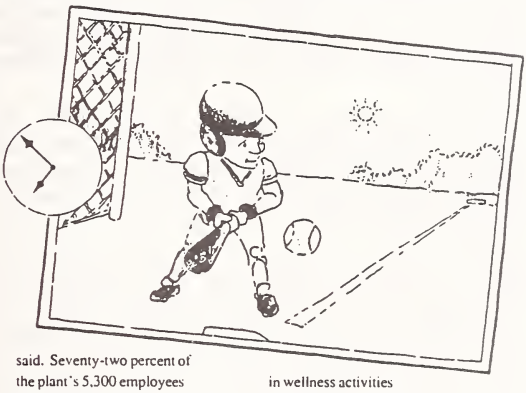
personnel costs," Coors said. That is a savings of $225,372.

A certified athletic trainer evaluates orthopedic injuries and develops a rehabilitation program for Coors workers. About 10% to 15% of workers evaluated are referred to outside physicians. But some of those use the Coors wellness center for rehabilitation of their patients, thus reducing costs, Coors said.

A particularly successful program at Coors is smoking cessation. Mr. Wright said Coors' smoking cessation program's success ratio ranges from 45% to 75% from group to group, compared with "the national success ratio for these programs of 15%," based on the number of participants who are not smoking one year after the program ends. Coors' smoking cessation program is successful, in part, because it includes a "two-week warm-up time," if necessary, Mr. Wright explained. And, "if you come in with a life crisis— a divorce or a new job, whatever— that's not the time to stop smoking," he said. Such employees are encouraged to sign up for the program at a later date.

But the main reason Coors' smoking cessation program is more successful than others is because it is 12 weeks long, as opposed to typical two-week programs, he said. "We started with the traditional two-week program and were getting a 25% success rate and feeling fat, dumb and happy," Mr. Wright said. But the longer program—which "includes follow-up to one year and beyond" and "a support system bringing in your family, your spouse or your significant other"—has proven far more effective, he said. Coors, like TI, has instituted a largely smoke-free workplace, with smoking permitted only in several designated areas.

TI's "Lifetrack" program—which is too young to have generated cost-benefit data—was well-received at its pilot location at a plant in Lewisville, Texas, Mr. McComas said. Seventy-two percent of the plant's 5,300 employees participate in the program, in line with TI's target of 70% worker participation. The program consists of three steps—orientation, assessment and presentation of results—each of which is conducted on company time.



First, TI employees complete an orientation in which they learn about the Lifetrack program. "We spend a great deal of time and effort on the presentation video and materials, and people have told us that the initial presentation speaks to the quality and effort put into the program," Ms. McComas said.

Next, a trained technician conducts fitness assessments, which includes a wellness profile that shows the relationship between the employee's health and his or her lifestyle habits, such as alcohol and tobacco use, vehicle safety, stress management, nutrition, exercise and dental hygiene. In addition, the assessment includes a physical fitness profile; a nutrition profile; and a personal well being profile, which provides a general view of the employee's outlook on life.

The technician then reviews the results individually with each employee. Employees are later given a confidential summary report of their health profile, attractively packaged and clearly detailed, with recommendations for participation in wellness activities and services available at TI.

"We use group data to create a strategic plan for each site," Ms. McComas said. For instance, after studying group data obtained at Lewisville in 1989, nutrition habits and obesity were areas targeted for improvement. A follow-up in February at Lewisville "indicates statistically significant changes" in those areas, Ms. McComas said.

With "Lifetrack" being gradually expanded to other TI facilities, TI began for the first time in January to offer employees and their dependents full coverage for preventive care procedures under the company's self-insured health care

Mr. JOSEPH. If I could comment, it's not just business. The State of Hawaii is now getting attention for its statewide health care program, and the emphasis there is on prevention and diagnostic and a de-emphasis on unnecessary treatment later because you missed it up front. So I think the debate in general is served by a greater focus on keeping people healthy, keeping them well, making them work out, etc.

The CHAIRMAN. They also have a mandated program in Hawaii.

Senator PELL. I have one other question. The present tendency is for the larger corporations to pay for health insurance and the little ones do not. Doesn't that mean in the end that it is going to be an unfair advantage to the little companies and corporations over the major corporations from the viewpoint of the cost of doing business?

Mr. JASINOWSKI. I think that is part of the problem, Senator, that the small companies would be more affected. I would like to make what may appear to be a self-serving point, and maybe it is, but it is important for the record to note it. When we surveyed our manufacturers, 98 percent of them provide health care. Very few manufacturing firms don't provide health care currently. This is a problem that is largely in the service arena, having to do with retail establishment, small service businesses and others. We are very concerned about those, but it is important to note the difference. That is where you don't have health care programs at all sometimes, and that is where you've got the big adjustment process.

Senator PELL. Thank you very much. I have no more questions.

The CHAIRMAN. Senator Adams.

Senator ADAMS. Mr. Chairman, thank you for holding the hearing this morning. Mr. Jasinowski, it is nice to see you again.

I have a specific question for Mr. Joseph, and it goes to this very point of what has happened, and I want to quote from your statement.

You indicate, Mr. Joseph, on page 1 that in 1971 you were paying $12 billion a year for group health, and it has now gone to $145 billion. On page 2, you say the key fact is that 63 percent of the uninsured earn less than $10,000 and that two-thirds of those uninsured or with lack of insurance earn less than $20,000. And then you go on to indicate that we're not dealing with this situation.

Now, what concerns me is this. The administration has bragged about producing a lot of jobs in the last 10 years, but these jobs are right where Jerry just pointed out; they are all in service industries, and they are $5 and $6 per hour, not $12 and $14 per hour jobs with the attached health benefits, which was the system that we were using, and Medicaid went with that.

Now that we have this huge number of people with low-paying jobs in this country, even with two people working who don't have the inability to pay $3,000 for health care, I want to ask you this. There was a proposal to cut Social Security, which did not pass, because we are taking in large amounts of Social Security—I think Senator Moynihan says we are taking in $1 billion or $1.5 billion per week more than we need for any kind of pay-as-you-go or pay-as-you-go with reserve.

Is it possible to break this Gordian knot for small business that we give a credit on this Social Security payment rather than cutting Social Security, to help assist them in paying for the health cost?

I have a whole series of cost containment proposals, and I agree with you we've got to have cost containment. But on the revenue side it would seem to me that since we are taking more out of the tax system in a very regressive system from all of these employees and employers now, that a portion from the employer and the employee might give small business an opportunity to participate in these basic programs because that is your point here, is that the problem is not with the big company but with these smaller services companies, and if we don't solve that, you're not going to support the bill, and we want you to support the bill.

Mr. JOSEPH. Well, that's the problem but it is manifested in two ways. Yes, the small employer by and large would like to be able to afford to provide health care to all of their people, but the underlying issue is that the health care costs have accelerated so fast that wages can't keep up with them.

Senator ADAMS. Suppose we just offer a package that you say is affordable—I don't know whether that is $3,000 or $2,500, but that is the total package—and out of that you ask the insurance industry—which we did before, incidentally, Senator Mikulski and I did—to structure a basic package of what can you buy for this amount. We were going to tie it to the minimum wage at that time. And Senator Kennedy rightfully said no, don't put part of the minimum wage into it.

But what I am looking for is a basic, already collected revenue source that will not injure the Social Security system, according to Senator Moynihan—and I believe him—and is already being paid by both employer and employee, that can put the small company into a position that the larger company that has much larger wages and much larger ability to pay for health plans, put them in the same position, so we can get this moving, whether it is single payer, double payer or whatever.

Mr. JOSEPH. Well, we supported Senator Moynihan's efforts in the first sense, and I believe what you are talking about as a proposition would be very interesting to many small businesses. Now, in terms of a specific policy recommendation, we would have to go through our council of small business, but I believe——

Senator ADAMS. Oh, I assumed that.

Mr. JOSEPH [continuing]. I believe they would find it interesting.

The CHAIRMAN. We've got about 4 minutes before the vote, and I don't want to cut it off. We've got three back-to-back votes, but you are more than welcome to come back and pick up.

Senator ADAMS. I will come back after the three back-to-back votes.

The CHAIRMAN. I think everyone will. I appreciate your comments. You know, we have to put this in some degree of perspective. If we go for a mandated program then we're not going to have the public cost. But then we hear that this will put the burden on the companies, and we're not meeting all of our responsibilities to the children or the millions of nonworkers who aren't included.

Now we come up with "pay or play" scheme, and now we're going to be expensive. You've got 33 million out there who basically don't have the resources to be able to afford coverage. Somebody is going to have to pay for it if we are serious about doing something about universal coverage and about quality control and about cost containment. We have to be able to pay for it. Somebody is going to have to. It is either going to be the Federal government or business or State and local government or consumers. There are only so many shelves out there. And what we have seen over the period of the last year is that as soon as you put the cups out one way, the others say, well, what about this area, and we can't do this. That is the dilemma we are facing. We need a good deal of help. I think we have made some important progress. I think this is the way to go.

We have appreciated the constructive recommendations that have been made. We are interested in the outcomes of your various studies and reviews, and I want to thank all of you for your constructive and positive presentations.

As we crank down more in terms of effective cost control, we have difficulties with those who are part of the system and who want to be in the position of being able to make judgments and decisions in terms of those aspects. And if we don't crack down, then we're not effective in terms of cost containment.

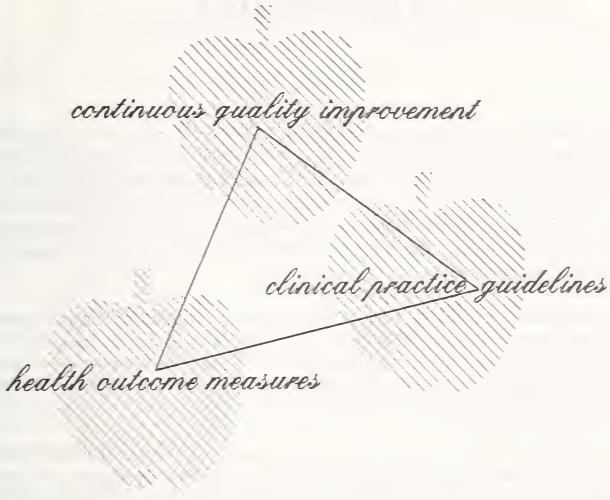
So the fact that everybody is uneasy may mean in this circumstance that we are a little closer to the target than we have been before.

Mr. JASINOWSKI. I think, Senator, you are absolutely right. You have taken on the most difficult domestic public policy issue that there is, in my opinion, and I think that you just have to apply burdens in certain areas.

If I could ask that the quality aspect be brought into this consideration again, though, because we can save an awful lot of money if we apply that, and I hope I can put a study we have done on it recently in the record.

The CHAIRMAN. Yes, we'll make that available.

[Article entitled "Buying Value in Health Care" from the National Association of Manufacturers by Mr. Jasinowski follows:]



Buying Value in Health Care

National Association of Manufacturers

Foreword

Historically, the U.S. health care system has provided the wrong reimbursement incentives by paying for the quantity rather than the quality of care delivered. Meanwhile, health care expenses topped $675 billion in 1990—more than a twofold increase since 1980. American businesses, which pay for employer health coverage, simply cannot remain solvent if such cost trends continue. To say our nation's productivity and future economic strength are at risk from soaring health care costs is not an overdramatization: It's a critical problem we must face—and resolve—now.

By rewarding providers for quality and efficiency instead of quantity, we will furnish strong motivation for reform of the health care system. We must start paying providers for what they do for people rather than what they do to people. Purchasers and consumers will then receive greater value for dollars spent and high-quality, efficient providers will be rewarded with increased market share.

This book seeks to (1) motivate employers to adopt a quality improvement strategy in their health plans; (2) inform health care providers about this employer commitment and enlist their cooperation; and (3) encourage policymakers to support the legislative and regulatory framework needed to integrate this strategy into both private and public programs. Some employers, health care providers and other groups noted in the Resources section of this book are already demonstrating the advantages of this approach. You are invited to consult them and to join NAM in its quest for delivery of the best quality health care at reasonable cost.

Jerry Jasinowski
President
National Association of Manufacturers

Executive Summary

The cost of health care in the United States soared throughout the 1980s, placing American businesses at a competitive disadvantage internationally and hampering efforts to expand coverage to the uninsured.

The Rand Corporation estimates that unnecessary and inappropriate care adds as much as 10 percent, or $75 billion, annually to health costs. Medical practice varies widely across the country; for example, residents of Boston are twice as likely to undergo a controversial stroke-preventing procedure as are residents of New Haven, Conn. A study of coronary bypass operations in one western state found that 14 percent of such procedures were unnecessary. Nationally, 230,000 bypass operations were performed in 1987 at an average cost of $28,000 each. Eliminating inappropriate use of this procedure alone could save $1 billion annually and improve quality of patient care by minimizing the risk of unnecessary intervention.

Efforts to contain such costs were the hallmark of the 1980s. In this decade, attention is focused on a broader quest for quality and value: providing necessary care at reasonable cost. The National Association of Manufacturers (NAM) believes the United States must undertake a national initiative to develop, coordinate and manage systems that measure and improve the quality of care. The goal of such an effort is to make more affordable, higher quality health care available to all. The federal government has already taken a first step by creating the Agency for Health Care Policy and Research (AHCPR).

At the heart of this quest for quality is shared information. Here, too, the effort must be national in scope. The AHCPR should serve as a clearinghouse—a national "nerve center," so to speak—for quality care information. Purchasers and providers should begin a new dialogue based on the following quality triad:

- adopting the Continuous Quality Improvement (CQI) model;
- incorporating and tracking new measures of patients' health outcomes; and
- following nationally derived clinical practice guidelines.

This quality triad requires providers to replace the traditional "quality by inspection" with mechanisms that build quality into the system—up-front and continuously throughout the process.

This book begins with an overview of a quality improvement strategy and a definition of quality health care. Chapter 2 examines quality and cost issues. Chapter 3 outlines the admirable initiatives launched by many companies, city and state governments, federal and private agencies and some providers. Chapter 4 details NAM's recommendations for a health care quality reform strategy.

All of us—businesses, labor, policymakers, insurers, providers and consumers—share responsibility for the ultimate success of this strategy. Together we must work toward a quality-based system that delivers value for the money spent. In every attempt to improve quality, our goal should be the same: Do the right job and do it right the first time, every time. Here, NAM offers concrete ways to make every attempt count.

chapter 1

Introduction and Overview

very year for the past two decades, the United States medical inflation rate has exceeded the consumer price index, often by a factor of two or more. Despite many private and public initiatives to control health care costs, medical inflation shows few signs of abating.

The federal government predicts that by the beginning of the 21st century, the nation's annual health care bill will be $1.5 trillion—or 15 percent of the gross national product (GNP). There is widespread concern that medical care may soon be unaffordable. A recent survey of National Association of Manufacturers (NAM) members, for example, showed that the cost of providing health benefits for employees, retirees and their dependents represented an amount equal to 37.2 percent of net corporate profits on average for responding companies. These financial burdens affect company profitability and the ability of corporate America to compete in world markets.

In the 1990s, due in part to concern over how cost containment initiatives affect the quality of medical care, the focus has broadened to encompass both elements. Providers are besieged with requests for data on the quality of care. They face demands for measures of quality that people with limited medical knowledge can understand. While there is much debate over *how* to define and measure quality of care, most agree that doing so is crucial to containing costs.

NAM believes that quality initiatives should be coordinated at a national level. Coordination will guard against duplication of efforts (which would add to an already costly delivery system) and improve consistency, thereby increasing the value of such information.

Goals of a Quality Improvement Strategy

NAM supports the development of a health care delivery system that—

- is affordable and cost-effective;
- continuously measures and improves its systems for delivering medical care;
- manages and coordinates patient care in ways that ensure optimal outcomes;
- uses technological and other health care resources appropriately and efficiently;
- promotes the prevention of disease or disability and early detection and treatment of such conditions;
- seeks the greatest possible improvement, not only in physical function, but also in patient physiological status, emotional and intellectual performance and comfort, as early as possible consistent with the best interests of the patient;
- gives purchasers and patients access to the quality and cost information necessary to make value-based health care purchasing decisions;
- encourages purchasers to use financial and other incentives to reward providers who improve patients' health status and prevent illness;

- encourages patients to take charge of their own health improvement through smoking cessation and related efforts; and
- involves patients in decisions affecting their own health, including treatment options and other clinical decisions.

Objectives of This Book

Of course, merely describing the model delivery system is not enough. Although health care goals tell us where we're headed, they don't answer such questions as "How do we get there?" or "What can I do to help?" This book addresses those questions. You'll find here not only a workable reform strategy, but a guide on how you can contribute to—and therefore benefit from—that strategy.

The intent is to furnish useful information, but equally important is what is *done* with that information. The objectives, therefore, are as follows:

- Help corporate chief executive officers and other senior executives understand why they must base health care purchasing decisions on *value* (high quality for a reasonable price) rather than on price alone.
- Outline steps for a national initiative to develop, coordinate and manage systems for measuring and improving population health status and quality of health care.
- Encourage health care delivery organizations to develop systems that measure and continuously improve the quality of care. This may include the use of treatment protocols and standards.
- Help the Administration, Congress, business, labor and the health care industry understand why developing standards and processes for defining, measuring and improving the quality of care can make care more affordable to all.
- Encourage the Administration, Congress, business, labor and the health care industry to promote healthy and safe lifestyles and support programs that measure and improve population health status.

What Is Quality Health Care?

To establish a more effective delivery system, we must first define "quality health care," then measure improvements in the U.S. population's health status against that definition.

> *Quality health care* consists of necessary medical processes that result in cure, significant measured improvement in the patient's condition, alleviation of pain or other desired outcome, and provides real value for the dollars spent. *Value* is necessary health care at reasonable cost. Value for money spent is the ultimate aim of health care purchasers.

Although this definition emphasizes the importance of *measuring patient outcomes*, it is important to evaluate the *process of care* as well. The following chapters will discuss how the process of care can be improved.

chapter 2

Quality and Cost Issues

ince the late 1960s, purchasers, providers, government agencies—and even consumers—have struggled to control medical inflation and minimize its adverse effects. During the 1980s, strategies to contain health care costs accelerated.

Unfortunately, the effectiveness of these strategies was limited because the focus was on price and use of services without adequate knowledge of quality. Also, cost management strategies often just shifted rising costs to those who were more likely to pay.

Rather than continue a piecemeal attempt at cost management, quality improvement must be built in from the beginning. Doing so will limit the need for cost controls and quality assurance tools. Only by incorporating quality improvement mechanisms ***into*** the system can purchasers ever hope to have a long-term impact on cost.

Measuring Quality

Historically, purchasers, consumers and providers have measured the quality of medical care on three dimensions:

1. *Structure* comprises the physical, human and organizational resources available to treat patients. Included are such items as the financial strength of the organization, equipment, and the number of doctors, nurses and social workers.
2. *Process* comprises institutional and professional procedures used to ensure that patients receive necessary care. Provider adherence to widely accepted practices and regulatory requirements are process examples.
3. *Outcome* encompasses changes in patient health status that can be attributed to the medical care received. Examples include mortality rates, hospital-acquired infection rates, results of patient satisfaction surveys and changes in an individual's physiological, social and psychological functioning.

The three dimensions were used to answer these important quality assessment questions:

- Does the health care professional or institution have the ***resources*** available to deliver quality care?
- Does the health care professional or institution have ***processes*** in place to provide effective, efficient and quality care?
- Does the health care professional or institution use ***resources and processes*** effectively to obtain optimal patient ***outcomes***?

It is easiest, of course, to identify and evaluate quality indicators such as information about the physical resources needed to treat patients as mentioned above, *e.g.*, the number of doctors and nurses. Today, however, purchasers, consumers and providers are interested in patient outcomes. It is not sufficient,

however, to consider patient outcomes alone. A patient can have inferior medical care, yet have a good outcome. The converse is also true.

Current Provider Quality Assurance Programs

Traditional provider quality assurance programs work toward identifying problems, particularly those stemming from misuse of medical services and unanticipated events such as a return to the operating room. Typically, individual patients' past medical charts are reviewed to determine if there was a generic or other "adverse event." The adverse events that hospitals usually search for include cardiac or respiratory arrest; organ failure (heart, kidney, brain, lung) not present on admission; post-operative complications such as infections; and hospital-based incidents such as a drug or blood transfusion reaction.

Traditional medical quality assurance processes often are similar to the inspection-based quality assurance programs that manufacturers have used for many years. For example, a finished manufactured part or product is inspected to ensure it meets specifications. Those that fail inspection are returned for rework or discarded. When too many parts or products are rejected, the company tries to find and correct the problem.

Medical quality assurance programs use a similar approach. Just as manufacturers inspect individual parts or products for defects, medical personnel "inspect" each patient's medical record to determine whether any patient experienced an adverse event. When this has occurred, the record and event are further investigated by appropriate medical staff to determine whether there is a quality problem. This method identifies quality problems *after* they have occurred.

Quality assurance staff may track problems, looking for trends that indicate recurrent, correctable, system-oriented problems. But this approach rarely results in making the necessary changes. Preventing the problem's reoccurrence involves finding out which step in the medical treatment process caused the problem, then fixing the process. Often, there is no organizational structure or procedure for doing so.

In some cases, preventing the problem from reoccurring may require drastic changes in certain individuals' behavior or that of the entire organization (a hospital, for example). The solution may require changing the organization's hierarchical structure, procedures or possibly long-established physician practice patterns.

Traditional quality assurance is well matched to physicians' traditional case-by-case orientation to treating patients. But the "one-case-at-a-time" approach fails to recognize health care delivery as a series of interlinked processes, or results. Furthermore, performance standards may not be strict enough. Why should we tolerate national average mortalities, for example, as the best comparative standard?

Finally, traditional quality assurance does not ensure quality; it merely evaluates quality by inspecting the end product. Although the reasons for quality defects may be identified and corrected, the focus is not on preventing problems through system design. Instead, the emphasis is on reviewing the end product and fixing quality failures after they have occurred. We must abandon quality by inspection. *Quality mechanisms must be built into the health care delivery system—up-front and continuously throughout the process.*

Why is real quality improvement so difficult? Because purchasers—

- lack systems to research and communicate empirical evidence regarding the relationship between medical treatments and patient outcomes. Providers should be responsible for this communication.
- lack systems to identify and correct the processes that lead to medical care quality

problems—*before* the problems occur, not *after* they occur.
- fail to recognize that support systems such as laboratory, radiology, housekeeping and risk management are equally important in ensuring quality. Poor performance, waste and inefficiency in carrying out these functions contribute to health care quality problems and costs.
- have no financial or other incentive systems to encourage providers to continuously improve the quality of care and patients' health.

Limits of Cost Containment

Purchasers, payers and providers have made major financial investments in developing and implementing cost-management strategies. There have been very few controlled research studies to date that evaluate the impact of these strategies on either health care costs or the health care delivery system.

Most employers do not have access to the type of rigorous controlled evaluations that would demonstrate the effect of individual cost containment programs on service use or costs over time. Often, this is because employers do not have databases and management information systems containing the community and company demographic information necessary for making useful comparisons. Furthermore, employers have access only to actual charge data, not to the true resource costs involved in patient care. Providers themselves often do not have a good accounting of these resource costs.

> "Quality mechanisms must be built into the health care delivery system—up front and continuously throughout the process."

To make meaningful evaluations and decisions, employers need (at minimum) community as well as employee demographic, utilization and cost-trend data over time. Employers should also understand the community health care marketplace and how the company's benefit package may affect utilization and costs.

Evaluating Care

Some purchasers, providers and consumers evaluate quality by looking for evidence of abnormal individual cases. This "evidence" often includes some of the quality indicators discussed earlier. But, here again, the information provided by such evaluations involves what happened in the past.

Medical science has not adequately researched how medical processes (or treatments) affect patient outcomes, including outcomes that patients themselves care about, such as relief from chronic pain. A physician, therefore, may not have adequate empirical information that compares how various medical treatments work under ideal controlled conditions vs. how they work in a typical medical setting. Without this, it's difficult for the physician to decide whether a particular treatment is appropriate for a given patient. It is nearly impossible, then, for an employer to determine whether the treatment is appropriate and, perhaps just as important, whether that treatment is yielding value for health care dollars spent.

Does this mean there are no standards against which the physician's performance (in diagnosing and selecting a treatment) can be evaluated? No, for we can determine whether a service, test or procedure is performed correctly in a technical sense. What we often cannot tell, though, is whether the service, test or procedure was the right thing to do. Here, then, lies the crux of the medical quality crisis: Although we can usually determine if "it was done right," we cannot determine if it was "the right thing to do."

Provider Incentives

Perhaps the most critical problem facing the health care industry today is the lack of incentives for providers to deliver cost-effective treatment, for they derive no direct benefit from doing so. Rewarding providers for cost-effective, efficient quality care rather than for quantity must become the norm if purchasers ever hope to derive value for health care dollars spent. Put simply, providers must be paid for what they do *for* people rather than what they do *to* people. We then will furnish strong motivation for reform of the health care system.

Abandoning Quality Assurance by Inspection

To learn if a procedure or medical intervention was the "right thing to do," we must first abandon quality by inspection. Many manufacturing and service companies have renounced these inspection-based quality assurance methods. Instead, they found it more cost-effective in the long term to use a quality model that identifies potential quality problems at the front end and designs quality problems out of the system that produces or delivers the product or service.

This approach changes the process. Instead of fixing failures after they have happened, failures are prevented. Here's how this approach can be applied to the medical care system:

- Understand that a health care delivery system is made up of a series of interlinked processes, and each has one or more results.
- Recognize that more than 85 percent of quality problems are caused by correctable system defects (errors in processes for producing or delivering the product or service), not by blunders made by individual workers (Deming, Crosby).
- Measure the result (*e.g.*, patient satisfaction) to determine whether the product or service meets requirements.
- Determine whether inferior or malfunctioning supplies (*e.g.*, defective pacemaker) are contributing to quality problems. If the problem is defective inputs, work with the supplier to correct the problem.
- Determine if one or more steps in the process (*e.g.*, mislabeling drugs) will lead to a product (or service) that doesn't meet customers' requirements. If the error is caused by some step in the process, correct the process.
- Periodically sample products and services (*e.g.*, patient surveys) to ensure they meet customer specifications and are defect-free. If a product or service in the sample is defective, reexamine the process and its inputs to find and correct the cause.

Chapter 3 gives specific examples of how the health care system is abandoning quality by inspection and applying some of the lessons on quality learned by progressive companies.

CQI: A New Era in Health Care

The new quality model in health care rests on the triad of *continuous quality improvement, outcomes management* and the *development of guidelines or standards on care.* They are necessarily related and complementary. Purchasers and providers must be familiar with all three to help guarantee value in their health care purchasing and delivery decisions.

Continuous Quality Improvement. Recognizing the limitations of inspection-based quality assurance, leaders in American medicine are motivating providers to adopt a new model, one of continuous quality improvement (CQI). Industrial quality experts suggest that *quality* can be defined as a *continuous effort by all members of an organization to meet the needs and expectations of the customer.* For health care purposes, this definition might be modified to substitute "patients and other customers" for the word "customer" (Laffel and Blumenthal).

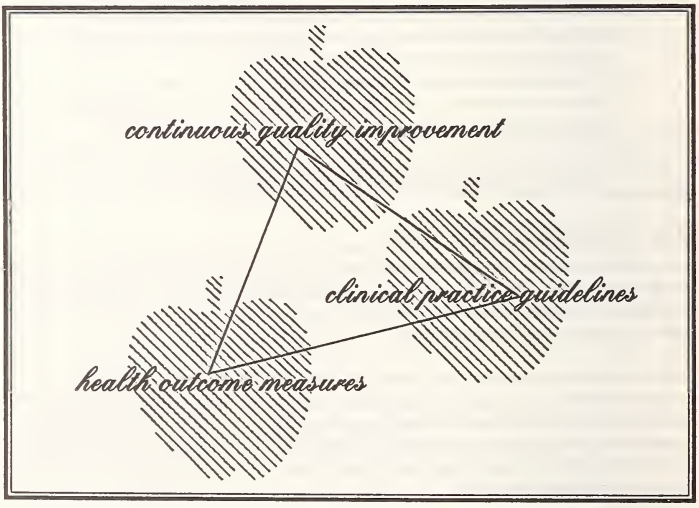
According to the leaders of CQI in American medicine, this redefinition of quality emphasizes: (1) striving to exceed existing standards; (2) studying the organizational processes by which care is provided; and (3) recognizing that patients' evaluations of their own care are valid indicators of quality (Laffel and Blumenthal). CQI recognizes and analyzes the variation inherent in all processes and strives to eliminate this variation.

Historically, the process of care was narrowly focused on clinical decision making by the physician. In other industries, managers view the process of production, for example, as complex and multidisciplinary. Applying this view to health care means we must include doctors, nurses, support staff and administrators who, together, make up the process or system. "For the average doctor, quality fails when systems fail. Doctors can remain trapped by defects they do not create but will nevertheless be held accountable for" (Berwick).

Processes must be the focus of our CQI efforts, and many processes are more complex than they need to be. Experts call this complexity the "costs of poor quality." Some experts estimate that 20 to 40 percent of every revenue dollar in industry goes to the cost of poor quality (Harvard Community Health Plan [HCHP], Deming, Crosby). More than half of these costs can be recovered by using CQI. If we make the processes used in health care simpler, we will save money and improve quality.

CQI uses statistical tools to analyze processes. It recognizes customer/supplier roles and teaches providers that, even in a hospital setting, transferring information or materials to another department sets up a customer/supplier role. When the supplier tries to meet the expectations and needs of the customer, the process operates with minimum complexity, waste and cost.

Providers traditionally have applied the scientific method to achieve breakthroughs in medical care. This same discipline (the use of data, the search for underlying causes, etc.) can be applied to achieve breakthroughs in medical processes that further improve efficiency (HCHP).



Not only are the theory and tools of CQI in health care intriguing, but there is evidence that they can be successfully applied. A national demonstration project funded by the Hartford Foundation has linked 20 leading hospitals with 20 quality professionals from industry. IBM worked with Massachusetts General Hospital; Corning Glass worked with the University of Michigan; and Ford Motor Company worked with Butterworth Hospital in Grand Rapids, Mich. The first-year experience of this project is encouraging: decreases in process complexity, in clinical variation and outcome, and in cost. The results of this ongoing national initiative are now reported annually at the National Forum on Quality Improvement in Health Care held in Boston, Mass.

Elsewhere, large hospital chains have enthusiastically adopted the CQI model. The Hospital Corporation of America began its CQI efforts in earnest in 1985 and has successfully woven in a commitment to quality throughout the organization. Providers from across the country come to the RHCA quality colleges for training and return to their respective institutions as quality cheerleaders (Batalden and Buchanan).

Intermountain Health Care, a Utah-based not-for-profit health care delivery company with 24 hospitals has been spearheading CQI efforts for the past five years, successfully cutting waste and improving the efficiency of care (James).

Finally, some providers have reduced unnecessary testing in the intensive care unit (Eagle, *et.al.*), becoming more efficient (Wachtel and O'Sullivan) and even awarding internal "grants" to help different hospital departments adopt CQI (Franklin, *et.al*). All these efforts deliver more value for the health care dollars spent. Space precludes naming the hundreds of other hospitals, HMOs and individual providers that have successfully embraced CQI.

What, then, are some steps that can be taken to implement CQI on a national scale? Donald Berwick, M.D., one of the leaders of the aforementioned Hartford Program, outlines six steps:

1. Leaders of health care institutions and purchasers must establish a shared vision of how CQI can transform health care.
2. Investments in quality improvement must be substantial to yield results, just as investments in other industries have yielded high dividends.
3. Respect for the health care worker must be re-established.
4. Open dialogue between customers and suppliers of health care must be thoughtful and continual.
5. Providers must use modern technical, theoretically grounded tools to improve health care processes.
6. Health care institutions must organize for quality by refining managerial techniques to tackle complex processes that cross customary departmental boundaries (Berwick).

Outcomes Management. The intense focus of CQI on process and its improvement complements another trend, one that relies on "outcome" measures. For decades, the only outcomes from medical care that were routinely evaluated were morbidity and mortality: illness and death. Today, several important societal forces have led to a renewed emphasis on evaluating outcomes and establishing guidelines (Brook).

The first of these forces is increased financial pressures on the health care system and the need to contain costs. Increased competition from different types of providers, like HMOs and PPOs, may also be a factor.

The second major force is the speed in which new technology is being introduced. This technology explosion is not solely concerned with complex, expensive machines; it also involves the emergence of information sciences and the adoption of new decision-making techniques by providers. The ability to

collate and computerize many different variables from large numbers of patients is a powerful tool.

The third force is new data that demonstrate high levels of inappropriate care and substantial geographic differences in the use of various medical procedures. These differences appear to persist even after accounting for the severity of the patients' illnesses. Such variations "raise questions about whether they reflect unnecessary costs in high-use areas or less-than-optimal care in low-use areas. The focus on outcomes is the obvious first step to answering these questions" (Epstein).

Outcomes management (Ellwood) routinely and systematically measures the functioning and well-being of patients, along with disease-specific clinical outcomes, at appropriate intervals. Valid indicators of health now include variables identified through patient interviews. Among these variables are satisfaction with the medical encounter, degree of disability and psychological well-being (Epstein).

Next, outcomes management pools clinical and the other types of data just described into a single database. It analyzes and disseminates results from the segment of the database most appropriate to the needs of each user, whether purchaser or provider. Paul Ellwood, M.D., the physician who first described this outcomes management system, believes the system can be modified and continuously improved as people's expectations change.

Is the outcomes management system working? Interstudy, a nonprofit think tank at Ellwood's headquarters in Excelsior, Minn., is tracking national experience with this concept. To date, dozens of large providers are systematically collecting information on patient satisfaction, functional evaluations and psychological well-being. They are trying to find out the answers to such basic questions as "How are you really doing, Mrs. Smith, and did that recent hip operation get you back on your feet?"

"Much provider decision making is arbitrary, highly variable, often based on poor evidence and shrouded in uncertainty."

In Cleveland, a consortium of providers and purchasers is pooling its resources and, among other advances, is systematically collecting patient satisfaction information using a nationally recognized questionnaire. Finally, reports from a two-year, three-city project called the "Medical Outcomes Study" (Tarlov, *et.al*) are just now appearing in the medical literature. The initial results are encouraging, indicating that patients are excellent judges of both the interpersonal and technical aspects of medical care.

Measuring outcomes will always have a role in evaluating quality because there will always be a need to know when poor outcomes are occurring (Laffel and Blumenthal). Clearly, the patient has an important role to play in this process. Even the best outcomes management system, however, does not provide insight into the causes of defects. That's why the previously described orientation to the *process* of care remains critical.

Guidelines and Standards. This interest in "the right thing to do" and "what works and what doesn't" is now being translated into guidelines for all providers to follow. Physicians have always followed protocols or clinical policies when making many clinical decisions. Yet, surprisingly, many of these protocols were too general to be useful. They lacked sufficient detail to discriminate between what is and what is not appropriate care (Leape). In addition, much provider decision making is arbitrary, highly variable, often based on poor evidence and shrouded in uncertainty.

Practice guidelines may present a partial solution, according to David Eddy, M.D., an advocate who has played a leading role in disseminating guidelines nationally. According to Eddy, guidelines may free practitioners "from the burdens of having to estimate the pros and cons of each decision. They can connect each practitioner to a collective awareness, bringing order, direction and consistency to their decisions. Practice policies can condense the lessons of research and clinical experiences, pool the knowledge of many providers and draw conclusions about appropriate practices."

In brief, medicine has become too complex and the volume of information too great for even the best-intentioned provider to assimilate. Practice guidelines will decrease the uncertainty inherent in all medical decisions. Finally, guidelines may especially help primary care providers who are under pressure to know more and more about a wider range of problems while the focus of specialists narrows.

There are multiple public- and private-sector efforts to write and disseminate clinical guidelines. For example, the federal government created the Agency for Health Care Policy and Research (AHCPR) in January 1990. AHCPR has elevated the activities of health policy research to a full public health service agency equivalent in stature to the Food and Drug Administration and the Centers for Disease Control (Woolf). Now the federal government, through AHCPR, will research, write and disseminate guidelines for providers.

In the private sector, at least 26 physician organizations have developed more than 700 practice parameters or guidelines (Kelly and Swartwout). These groups, such as the American College of Physicians in Philadelphia, Pa., then disseminate these guidelines to their physician members and encourage their widespread adoption. A private-public sector partnership called the Academic Medical Center Consortion (AMCC) was established by the American Medical Association, the RAND Corporation and 12 leading academic medical centers. The AMCC will develop appropriateness standards for selected expensive procedures, write practice guidelines and evaluate their effect on provider behavior.

> "Continuous quality improvement, outcomes management and the development of guidelines will create a strong new triad on which to rest the future of health care purchasing decisions"

Continuous quality improvement, outcomes management and the development of *guidelines* will create a strong new triad on which to rest the future of health care purchasing decisions. In the next chapter, we describe how the triad is holding up under the strain of real-world decision making.

chapter 3

Purchaser and Provider Initiatives

cross the country, a variety of initiatives that seek to address health care quality are under way. These initiatives are taking place at individual companies, within certain cities and states, and through various national organizations.

Employer Initiatives

Numerous individual corporations are seeking innovative ways to purchase value for their health care dollar. Purchasing value requires using concepts such as CQI. For example, Southwestern Bell Corporation, based in St. Louis, has entered into an agreement with a network of HMOs operated by the Prudential Insurance Company of America. Prudential, in turn, set up provider centers-of-excellence, channeling expensive high-technology cases such as kidney transplants only to those providers with proven track records for efficiency and quality.

In 1987, Allied-Signal saw its health care bill jump 39 percent to $355 million. In response, Allied created a single-supplier relationship (following a major component of CQI) with the CIGNA Corporation to provide health care services to its work force of 67,000 employees. Although the results are just now becoming available, Allied's innovative program can potentially provide them with a fixed rate of increase in health costs, stricter quality control measures, uniform data reporting and better assessment of outcomes, all geared toward improved quality at a lower cost (Nash and Goldfield).

The General Electric Company (GE), recognizing the previously described twin dilemmas of variations in practice and the lack of data on "doing what is right," is using quality-based information for a broad program of utilization review, employee education and dialogue with physicians (Laditka, *et.al.*). In New York State, for example, GE asked doctors to explain wide geographic variations in the rate and costs of coronary artery bypass surgery.

There are many other examples of innovative purchaser programs, including United Health Care and Honeywell, Xerox and U.S. Healthcare, Kaiser and UCLA, Alcoa and Interstudy's Outcomes Management System, and so on. Motorola is another company that developed its own preferred-provider network that includes case management for mental health and chemical dependency services and uses CQI in administration of all its health plans.

Of course, not every corporation has the resources of an Alcoa or GE for evaluating health care outcomes. Smaller firms can piggyback their efforts onto those of larger purchasers and begin the dialogue at a local level. The common thread tying together these disparate programs is a willingness to open the dialogue with physicians, cast aside hardened antagonisms and change from passive payors into savvy shoppers for health care.

Communitywide Initiatives

While Cleveland's program to systematically collect patient satisfaction information from all local hospitals is certainly a progressive step, other aspects of this joint provider-purchaser project are also worth noting. The Greater Cleveland Health Quality Choice Project will look at clinical outcomes from intensive care units throughout the city. A focus on high-volume, high-cost areas that are most important to purchasers—such as oncology, obstetrics and cardiovascular fields—will enable them to define specific patient groups, risk factors and outcome indicators. Another tenet of CQI is developing the ability to quantify quality. Purchasers in Cleveland are spearheading this effort.

Five hospitals in Rochester, N.Y., have signed an agreement with the state and Blue Cross that apparently would make them the nation's first hospitals to receive bigger payments if they achieve better clinical outcomes. The hospitals set aside 1 percent of their pooled revenues from all non-Medicare sources starting in 1988. From the pool, these hospitals will allocate extra daily payments to the hospitals that meet morbidity and mortality goals they establish for themselves.

The Hospital Experimental Program Phase III gives the hospitals a clear financial incentive to do a better job (Nash and Goldfield). An initial analysis of the Rochester experience has already highlighted differences in provider practice styles among just five hospitals in one city (Hartman, *et.al.*).

Statewide Programs

The Pennsylvania Health Care Cost Containment Council (HC4) was created in 1986 by Act 89, a state law that is a joint effort of business and labor interests. Act 89 empowers HC4 to collect, collate and publish the costs and outcomes for 57 major diagnoses from all Pennsylvania hospitals with more than 100 beds. These "Hospital Effectiveness" reports from HC4, although fraught with methodological problems, are virtually a consumer's guide to health care in the Keystone State. The Pennsylvania Business Roundtable, the Lehigh Valley Business Group on Health and the Delaware Valley Business Coalition on Health, among others, have all praised HC4's initial efforts.

The HC4 reports represent the first time that hospitals are being evaluated by an independent group, putting some pressure on insurers to scrutinize more carefully what they pay for. Other states, such as Florida, Iowa and Colorado, are considering similar mandatory reporting requirements for providers. Naturally, HC4 is a controversial project, but it has forced the outcome issue into the open.

On the other coast, Washington State has created the Foundation for Health Care Quality, a coalition of providers and purchasers that conducts innovative programs in outcomes evaluation. The foundation first embraced CQI and spread its gospel to its hospitals, corporations and doctors. It then obtained a large grant to study the usefulness of clinical outcome indicators and patients' judgments of quality as a way to improve the quality of obstetrical care. A newly created database will allow examination of the variations in electronic fetal monitoring and C-sections in addition to evaluating barriers to pre-natal care throughout the state.

National Programs

Various national organizations are attempting to use at least one component of the CQI outcomes management and guidelines triad. In a recent major report, the Institute of Medicine (IOM) of the National Academy of Sciences called for a dramatic overhaul of the quality assurance system for Medicare. The IOM report recommends that Medicare shift from its current focus on providers and process to a new focus on enrollees and outcomes.

Three goals of a 10-year plan for a new Medicare quality assurance system are: (1) institute CQI for all enrollee services; (2) strengthen the self-evaluation abilities of health care organizations and professionals; and (3) identify and overcome organizational and policy barriers to good quality of care.

The central theme of the recommendations to Congress (Lohr and Schroeder) is to abandon quality by inspection for quality improvement relying on practice guidelines, improved data systems, clinical indicators and a shrewder use of data collected—in short, building quality into the delivery process.

The American Medical Review Research Center (AMRRC), a nonprofit research and policy analysis center in Washington, D.C., will no doubt be involved in implementing some of the proposed dramatic shifts in Medicare. In addition, AMRRC wants to take the lessons learned in its work to the corporate buyer through its Corporate Physician Quality Value Training Program.

This program will teach corporate medical directors, seen as a possible liaison between purchasers and providers, the components of the new quality triad. In a similar move, the National Committee for Quality Health Care, a Washington, D.C.-based provider coalition, created the Task Force on Employer Communications to increase employer understanding of the pressures being exerted on the health care system.

On the provider side, the Quality Measurement and Management Project (QMMP) is a quality improvement initiative underwritten by 14 hospital systems representing more than 2,500 hospitals nationwide. This self-funded, three-year effort is testing a patient rating system, studying various results from heart attacks and spreading the CQI gospel to members. Most important, the QMMP is pooling provider-practice data on a massive scale, which will enable participating hospitals to fulfill many of the goals of the Paul Ellwood outcomes management program described in Chapter 2.

"The central theme of the recommendations to Congress is to abandon quality by inspection for quality improvement relying on practice guidelines, improved data systems, clinical indicators and a shrewder use of data collected—building quality into the delivery process."

Finally, and perhaps most importantly, the national oversight and accrediting body for all hospitals, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), has adopted a new program entitled the Agenda for Change. This bold program, using all three components of the new quality triad, will completely change how providers evaluate themselves. The JCAHO is moving away from relying solely on process indicators to requiring hospitals to collect outcomes information and perform a more rigorous self-evaluation of all procedures, physicians and systems. The JCAHO has also received grant support to develop a national database linking variables such as hospital staffing, physician credentials and insurance payment policies to patient outcomes.

chapter 4

A Health Care Quality Reform Strategy

ach party—providers, purchasers, the Administration, the Congress and patients—has a role to play in developing a quality-based health care system that delivers value for the dollars spent. State governments must also contribute by enacting data collection and dissemination laws and fostering a supportive legislative and regulatory environment.

Employers

Employers who pay the bills for private sector coverage must play a leading role in orchestrating the needed changes. It is up to the payors to demand such changes and accept no compromises. Here are some ways employers can contribute to a national effort to improve quality in health care.

1. Purchase health care based on value (quality at reasonable cost) rather than on price alone, backed up by the necessary internal expertise and resources to manage the health of employees and dependents. Small firms should piggyback on efforts undertaken by large firms.
2. Purchase health services only from "quality" providers, namely those who have adopted the CQI/outcomes management/practice guidelines triad.
3. Develop an information system that monitors the company's progress toward meeting cost management and quality improvement goals. This system should contain health and safety information, provider-specific service data and costs and other information needed to manage the health of employees over time.
4. Develop partnerships with providers and give them incentives to deliver value.
5. Educate employees and their families on how to identify and use providers with the highest value; assume responsibility to understand treatment options and probable outcomes; and adopt good preventive health habits. Small firms should use educational materials already developed by voluntary health agencies, hospitals, business-labor coalitions and other organizations.
6. Provide financial incentives to employees who achieve healthy lifestyles and reduce risks.

Physicians, Hospitals and Managed Care Organizations

Providers have the most to gain if reform is successful—and the most to lose if it's not. They can improve care in the following ways:

1. Implement the CQI model.

2. Acknowledge that health care quality can be measured and cooperate fully with initiatives to measure and improve standards of care.
3. Understand that high medical care costs are also caused by inefficiencies and waste in activities that support direct clinical patient care and work to improve these support systems.
4. Become quality providers.
5. Participate in and support initiatives to determine efficacy of medical interventions.
6. Disseminate practice guidelines that include expected results and use guidelines when treating patients, monitoring results and sharing information.
7. Recognize medical care as a system with inputs, processes and results. Use this concept to identify, resolve and prevent quality problems. Implement and refine quality models in all operations.
8. Work actively with purchasers and others in the community to reward healthy lifestyles and minimize health risks.

Administration and Congress

The Administration and Congress should develop a national strategy to improve the quality of health care. The strategy should support a legal/regulatory environment that promotes sharing/pooling/disseminating data and other critical quality information. Here are the components of this national strategy:

1. Purchase health care based on value rather than on price alone. Medicare and other government-funded health programs can serve as models for the private sector. For instance, the federal government should selectively contract for specific services with effective, efficient providers for the Medicare/Medicaid populations.
2. Make the Agency for Health Care Policy and Research (AHCPR) the national clearinghouse for quality-care information. All efforts to define, measure and improve the quality of care on a national scale should be coordinated through the AHCPR. In short, the AHCPR should become the "nerve center" of all national quality care initiatives.
3. Require that new technologies demonstrate effectiveness/appropriateness and cost/benefits, using the same standards that are applied to procedures, as a condition for reimbursement under Medicare and Medicaid. Make available such information to private employers and other payors.
4. Require that all states enact legislation mandating a uniform minimum data set for collecting hospital and physician treatment-outcome data and related cost; disseminate results to the public through a national data bank. The database and query system software must have adequate security mechanisms to ensure privacy and confidentiality.
5. Fund a national research agenda that addresses health quality improvement; include physician and medical research initiatives to improve quality of care, and medical practice guidelines validated through research on patient outcomes and patient satisfaction.
6. Support the development of educational systems to help all interested parties make the best use of the new quality-based system.

Patients

It's easy to understand that the best way to cut health care costs in the long term is to prevent illness or injury. As potential consumers of health care services, we all must take the following actions:

1. Do everything possible to ensure a healthy lifestyle, prevent illness and injury, and support family and friends in their efforts to improve health.
2. Take individual responsibility for learning about and using providers that deliver quality care at reasonable cost.
3. Volunteer for and support community and state efforts to reduce health and safety risks.
4. Become more involved in our own medical care by insisting on improved communication with our doctors on such topics as treatment options, living wills, organ donation, proper use of medications, resource limitations and the appropriateness of heroic measures to sustain life.

What Next?

Now that we have outlined a reform strategy for health care quality, what are the next steps for organizations interested in making it work? Some long-term steps are mentioned in this chapter, but there are things you can do today.

Contact the corporations, health care providers and other concerned groups listed in the Resources section of this book. Tell them you're interested in learning more about the CQI triad. Also contact community leaders and public policy makers in your area. Tell them you're committed to incorporating the CQI triad and to working with them to achieve the best quality health care at reasonable cost.

Today, begin building a system that delivers *value* for the money spent. All of us must accept—and pay for—no less.

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The CHAIRMAN. I know you have schedule problems. We'll recess for about 20–25 minutes. If you can remain, there were some additional questions from members.

So we'll be in recess. Thank you.

[Recess.]

Senator SIMON [presiding]. The committee will resume its hearing. We apologize to the witnesses. We are between other activities and floor activity, and Senator Kennedy is tied up on the floor right now with an amendment that he is handling.

Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

Let me try to focus in on cost control with each of you because as I was listening to your testimony, it seems to me that that was the focus of much of what you had to say, and my guess is that in the public policy that we formulate and develop, cost control is going to drive this debate, and it is going to be key to whatever we fashion here.

I'd like to start out with you, Mary Jane. You testified—and I was in the other room, but I got a note on this—that 89 percent of your members believe that we need major, not limited, reform.

Dr. ENGLAND. Yes.

Senator WELLSTONE. And you also testified that if the current pace of inflation continues, and spiralling costs continue, that your members are going to believe that a national health system is absolutely necessary.

Now, would this kind of system be a single-payer system?

Dr. ENGLAND. We don't have it that defined about what kind of system that would be. They just feel strongly that if there isn't some relief from the escalation of costs over the next 3 years, if we continue at a 15 percent increase that they would be willing to see some kind of national health system reform financed by the government, but they actually have not said what kind.

Senator WELLSTONE. I can tie this in with a question for you and others as well, but just to take it a little bit further, how long do you imagine it will take for your members to reach the point where they say costs are out of control, and we need to have major reform. Is the membership there now?

Dr. ENGLAND. My feeling is that there is a growing consensus, and I think it has been evidenced here this morning by the groups testifying. There is growing consensus here among the business community that we need some change sooner rather than later, and that's why we so strongly support much of the Mitchell bill and much of this HealthAmerica bill. We really feel that we don't want to wait any longer; we'd like to have the change now.

Senator WELLSTONE. Let me go on and talk about this Health Expenditure Board, but I'll start out from a somewhat different perspective and work back.

I think the GAO report came out in June. That report said that if we went to a single payer system like Canada—it doesn't have to be identical; I mean, we borrow from other nations what works, and we don't borrow what doesn't work—that we would save $67 billion in a year, and they pointed out that one-half of that savings would come from what we would save by way of insurance overhead, and the other half—again, we're still in bureaucracy—would

be what would be saved by hospitals and doctors just in terms of their bureaucracy costs of having to follow through with all the forms and whatnot.

My question for all of you is do you know of any other study which shows a greater potential for cost savings. I heard each of you talk about the importance of cost savings and your concerns about what skyrocketing costs would do to larger business or, for that matter, to smaller businesses.

Now, again, this GAO study talks about $67 billion in 1 year savings in administration, not coming from delivering care to people. And my question for each of you is do you know of any other study which can point to these kinds of savings by just focusing on the problem of administration and bureaucracy?

Dr. ENGLAND. I think there is also consensus that there is a lot of waste in the system currently. Arnold Drellman in the *New England Journal of Medicine* has clearly said there is waste, somewhere between 15 to 25 percent of waste in the current system. Some of it is attributed to inappropriate and unnecessary care. Some of it is attributed to defensive medicine. There have been a series of different kinds of studies that have shown there is actually waste in the system.

Certainly, business would support uniform claims forms to do away with a lot of the duplication of administrative costs. There is no question there is waste there, and we would agree.

I think there are some questions about the GAO study per se when you just focus on one small part. I'm not sure that it is as applicable in 1 year to this country as it would be applicable in Canada. So I think you'd have to look more closely. But there is evidence out there that there is tremendous waste in the system, and in fact that's what the Washington Business Group is very concerned about, that you just can't look at how you refinance the current system; you have to look at changing the current system. Our focus would be toward organized systems of care. If you only look at how to pay for it, you are going to be financing business as usual, and business as usual in this country is very costly in the health care area.

Senator WELLSTONE. Let me continue with this question for other panel members. I just want to be clear that this GAO study wasn't about Canada, so it isn't a question of whether or not we could apply what they estimated for savings in Canada to the United States. What they were saying was that if we adopted a single payer—their focus was on cost control and the whole problem of bureaucracy—that we could save up to $67 billion in this study. It is not Democrats or Republicans. It is a GAO study.

So my question is do you know of any other study that estimates anywhere close to these savings.

Mr. JASINOWSKI. Yes. First of all, I would agree with the importance of the administrative costs, and I don't want to detract from your point but I didn't want you to think that it was the most important focus in terms of cost savings.

I think the Rand studies, of which there have been a series, which have focused on the waste and quality deficiencies in the health care system—and in my testimony I cite a Rand study which suggests that $200 billion of potential waste and inefficient

quality, which would include the administrative costs you refer to, Senator, is quite likely or potentially to be the case.

So yes, there are studies. The issue of administrative waste is just part of a larger waste problem that has to do with what the Rand study documents, and that has to do with redundant care, inappropriate care. As I cited in my testimony, there are a variety of cases where we are doing 25–30 percent of care which is redundant, unnecessary, whether you are talking about hysterectomies or Caesareans or bypasses. That is going on, and that relates to malpractice. That is point number one.

Second, we were very intrigued with the single payer idea at the NAM and pursued that quite a lot, studied Canada a great deal. It has significant pluses. It is not something that in our opinion the United States could conceivably implement in anything less than a decade, given the State jurisdictional issues being so much more complicated in this country than they are in Canada.

You can get some of the same efficiencies from an all payer system, which needs to be considered. You can get some of the same administrative efficiencies from uniform forms, and you can get it from what Jeff Joseph suggested with respect to information technology.

So I think it is very important to focus on the administrative waste as you have. It should be broadened to include all quality, and we should look at solving that problem apart from a single payer solution, which I don't think this country is going to adopt in the near term.

Senator WELLSTONE. I'll hear from Mr. Joseph and then ask one quick follow-up and be done, Mr. Chairman.

Senator SIMON. You go right ahead.

Mr. JOSEPH. The observation about how long would it take for business to be fed up is a question I have had posed to me for almost 20 years now. We have a cost spiral that continues to go up, and we still have never figured out quite how to get a handle on it.

Now, cost containment has been the focus of business and the public sector working together since the mid-Seventies, and yet costs continue to escalate for a whole host of societal reasons.

What the GAO report showed to me was that, yes, a single payer system in Canada has lower administrative costs, and yes, in the United States there are perhaps 1,500 major players who all have information systems that don't talk to each other.

So the conclusion is not necessarily that you replace them all with a single payer here, but rather, you find a way to integrate all the information technology so you have the benefits that extend from the efficiencies of dealing in a common chain of thought and a common flow of information.

This country cannot afford the inefficiencies on the administrative side in our two sickest systems, which are health and education. If I could just digress to education for a minute, Al Shanker, who is head of the American Federation of Teachers, says 20 percent of the administrative costs in education are wasted. So we're talking about hundreds of billions of dollars systemically that we are just passing over and saying, yes, we've got to get at the administrative costs. But if you think about it, neither the health care system nor the education system are really high-tech in the admin-

istrative sense, and by applying that kind of process to both systems, I think you can free up a lot of dollars.

Senator WELLSTONE. Let me ask a concluding question which is back to the same question. I have no doubt that the Rand study looks at ways in which we need to have more accountability and that we could reduce other costs. I think when it comes to the actual delivery of care to people and where and how we have more accountability in relation to cost, that is an important area.

The reason I keep focusing on the administrative cost is it seems to me that that is where there is consensus. I mean, when you have a lot of bureaucracy and administrative costs, to the extent that you can reduce that, I think we should.

Now, Mr. Joseph, I understand your point about we can take advantage of much more sophisticated ways of communicating with new information technology, but it does strike me that the evidence—I will go back to the GAO study for myself, and maybe somebody can come up with other evidence—I don't know of one single study that has come out that is so clear in terms of one place, at least, where we could make tremendous inroads in terms of immediate cost control. And for my own part, the key to that is a single insurer.

Now, it could very well be, Jerry, that you could make the argument that it is different politics in Canada. That's true—although I would remind everybody here that the original model started out at the provincial level. It is a Federal system of government. We may want to see some models at State levels and see how that works and go at it in kind of an incremental basis. But I think there is much to be learned, and I guess my way of kind of finishing on this is to say to all of you that we are spending more money on health care than any other Nation. It would be gratuitous of me to spell out for you what this means in terms of per capita expenditure, what it means to the business community, but it does seem to me that the business community should be first now in lining up behind the door for cost control.

Mr. JASINOWSKI. Well, we certainly are, Senator.

Senator WELLSTONE. I noticed, Jerry, in your testimony you talked about the *New England Journal of Medicine* piece, and I think we ought to take a very close look at that.

Mr. JASINOWSKI. And I would just reinforce your focus on the administrative costs. I think all of us were saying that you have identified a very important problem area in the waste and quality thing, and that there are a variety of ways of solving it, and we'd like to work with you to reduce those administrative costs. It's a big number. Savings can be achieved.

Senator WELLSTONE. Thank you.

Thank you, Mr. Chairman.

Senator SIMON. Let me note the presence in the audience of Frances Howard, the sister of Hubert Humphrey, and Hubert Humphrey would be very much interested in this hearing. We are very happy to have you here, Ms. Howard. Thank you.

Senator WELLSTONE. And Mr. Chairman, let me just note that I talked to Frances as I came up, and she said, "I'm going to be kind of observing to see how you do," and I said, "Why don't you make me a nervous wreck?" [Laughter.]

Senator SIMON. Let me ask the former Illinois resident, now the president of the National Association of Manufacturers—we have been primarily talking more long-term solutions, but an immediate proposal that has been made from time to time is that we cap the deductibility of employer-paid health insurance. That clearly would be a tax increase for millions of Americans. Does your association have any stand on that particular proposal?

Mr. JASINOWSKI. That question, Senator Simon, goes to the larger question of the treatment of health care benefits and the paying of them by employers. There really are two sides to that debate. There are a significant number of people who think we ought to change our tax treatment of those benefits and who pays them to increase the price of health care and finance certain things, and those who think that it ought not to be.

Our association, to the extent it has focused on this in the past, would oppose the capping of the deductibility on health care, but there are members who would see some merit in looking at that. And I would be happy to look more carefully at it and try to give you a better sense of the pros and cons. In other words, it is not an absolutely clear-cut situation.

Mr. JOSEPH. The Chamber is also opposed to capping. What you get into when you start playing with who gets what, where, when and how, and discrimination rules, is you come to something very few people heard of a few years ago, and then they all heard about section 89. But you get into extremely complex administrative burdens trying to figure out whose benefits equal this and that.

It is an unnatural act to try and diminish Americans' desire to try to get better health care treatment and live longer. So I think the focus should try to be what former Secretary Califano wrote in the *New York Times* in May—let's try to get more health care for less money; let's see if we can liberate $100 billion from the system and spread that around to do the things we are trying to do.

Mr. JASINOWSKI. If I could, let me just have a mild disagreement with my colleague, Jeff Joseph, in the sense that I think that we really need to reduce the quantity of health care in this country in many cases. It is not correct to assume that we have the right level. In fact, there is too much emphasis on the quantity and not enough on the quality, and those of us who have argued we want to improve the quality is because we've got all this redundant care—and I'm sure that Jeff wasn't alluding to that entirely.

So I think that efforts to look at the tax question in general, there is some merit in trying to find what is the real price of health care.

Mr. JOSEPH. Business or government may not want to pay or reimburse certain procedures, but that doesn't diminish an individual's desire to do it themselves. That's my point.

Senator SIMON. Dr. England.

Dr. ENGLAND. I think this is an issue that big business is very concerned about, and if asked to have a vote today they probably would vote no. On the other hand, they are very concerned about the issue of the systems of care, and if there could be some consensus about what kind of health system we'd have in this country, there are members of the Washington Business Group on Health

who would move to support some kind of re-look at the taxability of health benefits.

Senator SIMON. OK. If I could just add one more comment, I was reading your statement, Mr. Jasinowski, and I noticed you said 98 percent of your employers offer health care, and you talked about the staggering increases. I could not help but recall a small manufacturer in Illinois who told me they had budgeted $800,000 for health insurance, and the bill came in at $1.4 million. So he is ready for almost any kind of a radical solution. But in addition to paying for his own employees through taxes, he helps to pay for the uninsured. So there is a double hit that a lot of your members are getting.

Mr. JASINOWSKI. I think that is right, and I would like to say that I think that our membership is fed up with the excessive cost and low quality of the current health care system and are ready for major changes, and that represents a change for the manufacturers from four or 5 years ago, and that has to do with escalating quality, poor efficiency, and the fact that everything from training our employees to new innovation is eaten up by health care costs.

We at the NAM last year budgeted about $500,000 for health care. My bill came in at $840,000 in 1 year. It does focus the mind of small manufacturers, medium manufacturers and large manufacturers. So I think we are all of the mind that we need major change. The issue is what kind of change. We put the emphasis on quality and cost containment first so that we can afford the access, but we certainly support moving forward with access as well.

Senator SIMON. We thank you for your testimony. We appreciate it a great deal.

Our next panel is composed of people who represent major organizations of health care providers who are going to be playing a major role in this whole debate. The panel includes Barbara Redman, executive director of the American Nurses Association; Dennis Barry, president of Moses Cone Memorial Hospital and former chairman of the policy committee of the American Hospital Association; Mike Bromberg, president of the Federation of American Health Care Systems; and Dr. James Todd, executive vice president of the American Medical Association.

We are pleased to have all of you here, and Ms. Redman, we'll hear first from you.

STATEMENTS OF BARBARA K. REDMAN, EXECUTIVE DIRECTOR, AMERICAN NURSES ASSOCIATION; DENNIS R. BARRY, PRESIDENT, MOSES H. CONE MEMORIAL HOSPITAL, GREENSBORO, NC, FORMER CHAIRMAN, POLICY COMMITTEE, AMERICAN HOSPITAL ASSOCIATION; MIKE D. BROMBERG, PRESIDENT, FEDERATION OF AMERICAN HEALTH CARE PROGRAMS; AND DR. JAMES S. TODD, EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Ms. REDMAN. Thank you, Senator.

I am Barbara Redman, executive director of the American Nurses' Association. We appreciate this opportunity to present this testimony on behalf of HealthAmerica and would like to make the following comments.

We believe that access to high quality, affordable health care is a growing concern. Nurses, as you know, are on the front line of the health care system. We deliver many of the essential health care services, and we see in our practice people who are denied or delayed in obtaining appropriate care because of financial barriers.

We do know that delayed care is associated with problems of increased morbidity and mortality and lost productivity, and unfortunately, the most vulnerable are among the uninsured groups whose complex and diverse needs are not well-met by the existing system.

A plan which encompasses the nursing profession's best vision of a reformed health care system for the future has been developed by the American Nurses' Association and the National League for Nursing, with the assistance of State associations and specialty nursing groups. Forty-five national nursing organizations, or 525,000 registered nurses, have endorsed nursing's agenda for health care reform.

We commend the sponsors of S. 1227 for leadership in this time of health care crisis. The bill shares several key elements with nursing's agenda. Shared components include public responsibility for ensuring universal access, carefully thought-out incentives for each individual to assume greater self-responsibility to achieve health, and building on existing employer-based health insurance.

The American Nurses Association supports targeting removal of financial barriers to health care in this bill, and its comprehensive financing reform package is congruent with our position.

The bill extends access to a core of health care services and balances public and private payers' responsibility. We also believe the commendable emphasis on managed care will decrease costs and improve quality of the services delivered.

Appropriate State administration of the public plan and lower copayments and deductibles for preventive services are steps toward cost containment. We support utilization of practice and outcome guidelines for quality assurance and for comprehensive evaluation of new technologies prior to use.

We look forward to working with you in the refinement of this bill. We believe that it can be strengthened by implementing regulatory and payment incentives to ensure a balance between treatment of illness and promotion of health, and by valuing and incorporating health education and counseling as an integral part of the health care system.

Additionally, we believe that utilization and reimbursement of a full range of providers is central to access to care. Freedom of provider choice must be integral to the delivery of health care services envisioned by HealthAmerica.

Nursing continues its review of your bill and other health care reform proposals and our own agenda, and we will pursue implementation of common goals and clarification and resolution of differences.

Thank you, Senator, for the opportunity to share our views. We look forward to continuing our work with this committee to ensure the implementation of responsive health care reform in the country.

[The prepared statement of Ms. Redman (with attachments) follows:]

Prepared Statement of Ms. Redman

Mr. Chairman: I am Barbara Redman, Ph.D., R.N., F.A.A.N., Executive Director of the American Nurses Association. Thank you for the opportunity to present this testimony on S. 1227, Health America: Affordable Health Care for All Americans.

The American Nurses Association (ANA) is the only full-service professional organization representing the nation's two million registered nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace through a comprehensive workplace advocacy program, projecting a positive and realistic view of nursing to the public and by working with the U.S. Congress and regulatory agencies on issues affecting nurses and the public.

Access to high quality, affordable health care is of growing concern to millions of Americans—not only to the over thirty-seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage because of pre-existing conditions or that the skyrocketing costs will make dependent coverage or their own out-of-pocket costs unaffordable.

America's two million registered nurses deliver many of the essential health care services in the United States today. Working in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care arrangements—nurses know first band of the inequities and problems with our nation's health care system. Because we are there—twenty-four hours a day, seven days a week—we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

We see people on a daily basis who are denied or delayed in obtaining appropriate care because of their inability to pay or their lack of adequate health insurance. These people often postpone seeking help, until they appear in a hospital emergency room in advanced stages of illness or with problems that could have been treated earlier in less costly settings or, more appropriately, prevented altogether with earlier treatment or prevention services.

We know that delayed access to needed care is associated with problems of increased morbidity and mortality as well as countless hours of lost productivity in the workplace. Infants and children, pregnant women, the frail elderly, people with persistent health problems, rural and inner city residents and minorities are disproportionately represented among these most vulnerable uninsured groups. Their complex and diverse needs are not met by the existing system.

America's nurses believe that it is time to frame a bold new vision for reform—one that keeps what works best in our current system, but casts aside institutions and policies that fail to meet present and future needs—a plan that addresses the triad of problems that exist in the current system: inequitable and limited access, soaring costs and inconsistencies in quality and appropriateness of the care delivered.

For the past two and half years, under the leadership of American Nurses Association (ANA) and the National League for Nursing (NLN), nursing has been developing a plan which encompasses the profession's best vision of a reformed health care system for the future. To ensure that all areas of specialty nursing practice and unique geographic differences were sufficiently represented in the development of this plan, ANA convened a special task force of nursing experts. They evaluated the current health care system in the United States, as well as those of other nations and subsequently developed a plan for reform. The work of the task force was disseminated to all fifty-three of our state and territorial nurses associations, all of the national nursing organizations representing specialty areas of nursing practice and to the chiefs of the federal nursing services for review and comment. Drafts of the plan were discussed at national meetings and in regional conference calls throughout its development.

To date, forty-five national nursing organizations have endorsed this proposal for health care reform entitled, *Nursing's Agenda for Health Care Reform* (a list of endorsing organizations and a copy of the *Agenda* is attached). These forty-five organizations represent over 525,000 of the nation's two million registered nurses.

Mr. Chairman, as you know, many other highly respected and qualified groups have also studied the growing crisis in health care and have come forward with reform proposals of their own. Unfortunately however, most of these plans have focused primarily on the problems of the high cost and the financing of health care services.

Nurses believe that framing the problem this narrowly will not result in solutions that will adequately achieve the desired outcome: universal access to affordable and timely health care that is appropriate, necessary and that ultimately results in the improved health status of all Americans.

Nursing defines the health care crisis problem in terms of the need to restructure, reorient and decentralize the health care system in order to guarantee access to services, contain costs and ensure quality care. Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive, and not focused only on one or two components of the problem. Nursing's proposal does not define the problem only in terms of the uninsured or underinsured; rather, it addresses the health care needs of the entire Nation.

Nursing's Agenda for Health Care Reform calls for building a new foundation for health care in America while preserving the best elements of the existing system.

There are several key features and principles which characterize *Nursing's Agenda for Health Care Reform.* Some clearly bear similarity to S. 1227 and are included here in order to provide context for ANA's comments on the legislation. Significant components include:

—access for all citizens and residents will be provided through a restructured health care system which enhances consumer access to services by delivering primary health care in community-based settings; the new system will facilitate utilization of the most cost-effective providers and therapeutic options in the most appropriate settings;
—there will be a Federally-defined package of essential services, financed through public and private plans and sources; there will be an emphasis on health promotion/disease prevention;
—there will be a phase-in of essential services, starting with pregnant women and children, and continuing with the vulnerable populations who historically have had limited access;
—public plans will be administered by the states;
—there will be co-payments/deductibles which are eliminated for those under 100 per cent of the poverty level; and reduced for those between 100 and 200 percent of poverty level;
—managed care is encouraged with incentives;
—insurance reform will be required, including community rating and reinsurance pools;
—practice and outcome guidelines will be encouraged for quality assurance;
—state or regional public/private sector review will be utilized to control costs, system growth, rates and premium levels;
—there will be provisions for long term care which prevent impoverishment and which facilitate assuming individual responsibility to financially plan for long term care;
—cost containment strategies will include decreasing administrative requirements and eliminating unnecessary bureaucracy; and
—a shift in focus to provide a better balance among treatment of disease, health promotion and illness prevention such as coverage for:

  —immunizations
  —prenatal care
  —health screening which has proven effective in preventing costly and devastating disease (e.g., colorectal exams, pap smears, mammography)

Throughout the *Agenda,* there is a focus on locating primary health care convenient to the consumer . . . in schools, in workplaces and in the community. There is also an emphasis on ensuring the consumer has access to a full range of qualified providers.

Mr. Chairman, nursing is pleased to work with you and members of the Committee to implement universal access to health care for all Americans. We welcome the opportunity to describe nursing's plans for design of a new health care system. . . . one that enables us to continue providing our knowledge and skills to those who need it.

S. 1227, Health America

The American Nurses Association commends the Senate Democratic leadership in this time of health care crisis, and for their introduction of S. 1227, Health America: Affordable Health Care for All Americans.

ANA is particularly pleased that S. 1227 shares several key elements of *Nursing's Agenda.* Both include public responsibility for assuring universal access, as well as

carefully thought out incentives for each individual to assume greater self-responsibility to achieve health. Both build on the existing employer-based health insurance that already exists today.

ANA believes this legislation accurately targets removal of financial barriers to health care as a major goal in health care reform. Health America provides a comprehensive health care financing reform package which will extend access to a core of health care services for those who currently experience financial barriers to health care, and the bill proposes a balance between public and private payers to allow meaningful choices by employers, providers and consumers of health care.

ANA believes that S. 1227 has a commendable emphasis on managed care, which will encourage utilization of the most cost-effective and cost-efficient providers of most health care services, especially for those services which focus primary care and restorative care on health promotion and disease prevention. Nursing believes that the managed care system of the future can and must incorporate techniques that can be effective in improving quality, providing preventive care, emphasizing proper health and controlling health expenditures.

The goal of managed care should be to provide timely, necessary and appropriate care by the most appropriate qualified provider in the most appropriate setting. Achieving this goal will decrease costs and improve quality of the services delivered. In the past, managed care has been used in many instances to protect the pocketbooks of insurers, rather than the needs and rights of consumers. Care must be taken to retain the maximum possible consumer choice and to place a premium on services that address the needs of the consumer.

Use of nurses in case management is one method increasingly being utilized within managed care to address the complex health care needs of clients with continuing and chronic health problems. The aim of case management is to make health care less fragmented and to integrate, coordinate and to advocate on behalf of those clients requiring extensive services. Case management is also cost-effective because it allows early diagnosis and treatment of acute episodes of illness often before they require expensive high-technology. We believe that S. 1227 appropriately provides for state administration of the public plan and we are pleased that preventive services will have lower co-payments and deductibles. We applaud Health America for planning to utilize practice and outcome guidelines for quality assurance, and for comprehensive evaluation of new technologies prior to use.

While we would like to see reform of the health care system occur as quickly as possible, we, too, recognize that it may be necessary to implement these fundamental changes incrementally. We believe that if this is necessary, that the first priority should be the immediate coverage of all pregnant women and children under six years of age, and those individuals who demonstrate a health status seriously compromised by a history of inadequate care.

We will bring to our continuing discussions with you, Mr. Chairman, some points within the bill. For example, we believe S. 1227 would be strengthened by implementing regulatory and payment incentives to ensure that a balance is maintained between treatment of illness and promotion of health. Practically, that means valuing and incorporating as an integral part of health care delivery the health education and counseling roles which nurses have traditionally incorporated into nursing practice. The incorporation of these roles into practice has increased patient/consumer ability to manage their health status to achieve improved health outcomes, especially for those with multiple chronic illnesses.

Additionally, utilization and reimbursement of a full range of providers is central to access to care. Our observations over the years demonstrate that the historical and regulatory barriers to patients' and families' freedom to choose the provider of their choice limits access to high quality care and to providers such as nurses. We believe that to fully implement the intent and the scope of this legislation, freedom of provider choice must be integral to the delivery of health care services envisioned by Health America.

Nursing continues its review of S. 1227 and other health care reform proposals. Nursing will continue to examine our own agenda. With nursing colleagues, business, labor and consumer groups, we will pursue implementation of common goals and clarification and resolution of differences.

Mr. Chairman, thank you for this opportunity to share our views. We look forward to continuing our work with this Committee, to ensure the implementation of responsive health care reform.

Nursing's Agenda For Health Care Reform

EXECUTIVE SUMMARY

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. This document presents nursing's agenda for immediate health care reform. We call for a basic "core" of essential health care services to be available to everyone. We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care.

The basic components of nursing's "core of care" include:

- A restructured health care system which:
  - — Enhances consumer access to services by delivering primary health care in community-based settings.
  - — Fosters consumer responsibility for personal health, self care, and informed decision making in selecting health care services.
  - — Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.
- A federally-defined standard package of essential health care services available to all citizens and residents of the United States, provided and financed through an integration of public and private plans and sources:
  - — A public plan, based on federal guidelines and eligibility requirements, will provide coverage for the poor and create the opportunity for small businesses and individuals, particularly those at risk because of preexisting conditions and those potentially medically indigent, to buy into the plan.
  - — A private plan will offer, at a minimum, the nationally standardized package of essential services. This standard package could be enriched as a benefit of employment or individuals could purchase additional

services if they so choose. If employers do not offer private coverage, they must pay into the public plan for their employees.

- A phase-in of essential services, in order to be fiscally responsible:
  - — Coverage of pregnant women and children is critical. This first step represents a cost-effective investment in the future health and prosperity of the nation.
  - — One early step will be to design services specifically to assist vulnerable populations who have had limited access to our nation's health care system. A "Healthstart Plan" is proposed to improve the health status of these individuals.
- Planned change to anticipate health service needs that correlate with changing national demographics.
- Steps to reduce health care costs include:
  - — Required usage of managed care in the public plan and encouraged in private plans.
  - — Incentives for consumers and providers to utilize managed care arrangements.
  - — Controlled growth of the health care system through planning and prudent resource allocation.
  - — Incentives for consumers and providers to be more cost efficient in exercising health care options.
  - — Development of health care policies based on effectiveness and outcomes research.
  - — Assurance of direct access to a full range of qualified providers.
  - — Elimination of unnecessary bureaucratic controls and administrative procedures.
- Case management will be required for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers' active participation in decisions about their health, and create an advocate on their behalf.

- Provisions for long-term care, which include:
  - — Public and private funding for services of short duration to prevent personal impoverishment.
  - — Public funding for extended care if consumer resources are exhausted.
  - — Emphasis on the consumers' responsibility to financially plan for their long-term care needs, including new personal financial alternatives and strengthened private insurance arrangements.
- Insurance reforms to assure improved access to coverage, including affordable premiums, reinsurance pools for catastrophic coverage, and other steps to protect both insurers and individuals against excessive costs.
- Access to services assured by no payment at the point of service and elimination of balance billing in both public and private plans.
- Establishment of public/private sector review — operating under federal guidelines and including payers, providers, and consumers — to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. This review would progress in a climate sensitive to ethical issues.

Additional resources will be required to accomplish this plan. While significant dollars can be obtained through restructuring and other strategies, responsibility for any new funds must be shared by individuals, employers, and government, phased in over several years to minimize the impact.

NURSING'S AGENDA FOR HEALTH CARE REFORM

Nurses provide a unique perspective on the health care system. Our constant presence in a variety of settings places us in contact with individuals who reap the benefits of the system's most sophisticated services, as well as those individuals seriously compromised by the system's inefficiencies.

More and more, nurses observe the effects of inadequate services and of the declining quality of care on the nation's health. Firsthand experience tells us that the time has come for change. Patchwork approaches to health care reform have not worked. While preserving the best elements of the existing system, we must build a new foundation for health care in America. It is this realization that drives *Nursing's Agenda For Health Care Reform.*

Nursing's plan for reform converts a system that focuses on the costly treatment of illness to a system that emphasizes primary health care services and the promotion, restoration, and maintenance of health. It increases the consumer's responsibility and role in health care decision making and focuses on partnerships between consumers and providers. It sets forth new delivery arrangements that make health care a more vital part of individual and community life. And it ensures that health services are appropriate, effective, cost efficient, and focused on consumer needs.

A HEALTH CARE SYSTEM IN CRISIS

The strengths and weaknesses of our nation's health care system are well documented. Every day, many Americans profit from the system's technological excellence, extensive medical research, well-educated health professionals, diverse range of providers, and myriad of facilities. Millions of people live longer lives because of the care they receive.

But America's health care system is also very costly, its quality inconsistent, and its benefits unequally distributed. Although the system provides highly sophisticated care to many, millions of Americans must overcome enormous obstacles to get even the most elementary services. In short, health care is neither fairly nor equitably delivered to all segments of the population.

As caregivers in a diversity of settings, responsible for providing care and coordinating health care services 24 hours-a-day, nurses clearly understand the implications of the system's failings. The more than two million nurses in America are at the front lines — in hospitals, nursing homes, schools, home health agencies, workplaces, community clinics, and managed care programs. And what nurses see are the alarming effects of a system that has lost touch with the communities it is supposed to serve:

- More and more people must overcome major barriers to gain access to even the most elementary services.
- Too many Americans receive treatment too late because they live in inner cities or in urban or rural areas where service levels are inadequate.
- People enter hospitals daily in advanced stages of illness, suffering from problems that could have been treated in less costly settings or avoided altogether with adequate disease prevention and health promotion services.
- The lack of access to prenatal care contributes to an alarming number of infant deaths and low birth weights each year.
- Obstacles to obtaining fundamental services, such as childhood immunizations, are largely responsible for a resurgence in preventable diseases.
- Disproportionate amounts of resources are used for expensive medical interventions, which all too often provide neither comfort nor cure.
- Every year, expensive nursing home care impoverishes an alarming number of residents and their families.

Major changes in the health care system can no longer be put on hold. Further analysis and investigation will neither change the facts nor diminish the problems.

Today, more than 60 million Americans are either uninsured or underinsured. This fact alone cries out for health care reform. Now, the system's inability to contain costs is placing more and more Americans with "adequate" insurance coverage at risk of hardship when major illnesses do occur. Employers and employees alike are desperately seeking solutions to the dual problems of rising health care costs and increased premium rates that threaten basic coverage for most American workers and their dependents.

Americans cannot afford to sit idly and do nothing. Health care costs are approaching 12 percent of the gross national product (GNP). Health care is expected to cost over $756 billion in 1991.[1] If nothing is done to control expenditures, health care spending is expected to reach $1.2 to $1.3 trillion by 1995 — an increase of some $500 billion in less than five years. At this rate, if the system remains unchanged, spending will reach between $2.1 and $2.7 trillion by the year 2000.[2]

THE FRAMEWORK FOR CHANGE

Nurses strongly believe that the health care system must be restructured, reoriented, and decentralized in order to guarantee access to services, contain costs, and ensure quality care. Our plan — the product of consensus building within organized nursing — is designed to achieve this goal. It provides central control in the form of federal minimum standards for essential services and federally defined eligibility requirements. At the same time, it makes allowances for decentralized decision making which will permit local areas to develop specific programs and arrangements best suited to consumer needs.

Nursing's plan is built around several basic premises, including the following:

- All citizens and residents of the United States must have equitable access to essential health care services (a core of care).
- Primary health care services must play a very basic and prominent role in service delivery.
- Consumers must be the central focus of the health care system. Assessment of health care needs must be the determining factor in the ultimate structuring and delivery of programs and services.
- Consumers must be guaranteed direct access to a full range of qualified health care providers who offer their services in a variety of delivery arrangements at sites which are accessible, convenient, and familiar to the consumer.
- Consumers must assume more responsibility for their own care and become better informed about the range of providers and the potential options for services. Working in partnership with providers, consumers must actively participate in choices that best meet their needs.
- Health care services must be restructured to create a better balance between the prevailing orientation toward illness and cure and a new commitment to wellness and care.
- The health care system must assure that appropriate, effective care is delivered through the efficient use of resources.
- A standardized package of essential health care services must be provided and financed through an integration of public and private plans and sources.

- Mechanisms must be implemented to protect against catastrophic costs and impoverishment.

The cornerstone of nursing's plan for reform is the delivery of primary health care services to households and individuals in convenient, familiar places. If health is to be a true national priority, it is logical to provide services in the places where people work and live. Maximizing the use of these sites can help eliminate the fragmentation and lack of coordination which have come to characterize the existing health care system. It can also promote a more "consumer friendly" system where services such as health education, screening, immunizations, well-child care, and prenatal care would be readily accessible.

At the same time, consumers must be the focus of the health care system. Individuals must be given incentives to assume more responsibility for their health. They must develop both the motivation and capability to be more prudent buyers of health services. Promotion of healthy lifestyles and better informed consumer decisions can contribute to effective and economical health care delivery.

Finally, in implementing reforms, attention must be directed to the unique needs of special population groups whose health care needs have been neglected. These individuals include children, pregnant women, and vulnerable groups such as the poor, minorities, AIDS victims, and those who have difficulty securing insurance because of preexisting conditions. Lack of preventive and primary care for this sector has cost the nation enormously — both in terms of lives lost or impaired and dollars spent to treat problems that could have been avoided or treated less expensively through appropriate intervention.

Access to care alone may not be sufficient to resolve the problems of these vulnerable groups. For those individuals whose health has been seriously compromised, a "catch up" program characterized by enriched services is justified. Coverage of pregnant women and children is critical. This first step represents a cost effective investment in the future health and prosperity of the nation.

It is this set of values that distinguishes nursing's plan from other proposals and offers a realistic approach to health care reform.

A PLAN FOR REFORM

Nursing's plan for health care reform builds a new foundation for health care in America. It shifts the emphasis of the health care system from illness and cure to wellness and care. While preserving key components of the existing system, it sets forth new strategies for guaranteeing universal coverage; making health care a more vital part of community life; and ensuring that the health care services provided are appropriate, effective, and cost efficient.

The following pages provide a general overview of nursing's vision for a better health care system.

UNIVERSAL ACCESS TO A STANDARD PACKAGE OF ESSENTIAL SERVICES

Nursing's plan envisions a new and bold approach to universal access to a standard package of essential health care services and the manner in which these services are delivered.

The federal government will delineate the essential services (core of care) which must be provided to all U.S. citizens and residents. This standard package will include defined levels of:

- Primary health care services, hospital care, emergency treatment, inpatient and outpatient professional services, and home care services.
- Prevention services, including prenatal and perinatal care; infant and well-child care; school-based disease prevention programs; speech therapy, hearing, dental, and eye care for children up to age 18; screening procedures; and other preventive services with proven effectiveness.
- Prescription drugs, medical supplies and equipment, and laboratory and radiology services.
- Mental health services and substance abuse treatment and rehabilitation.
- Hospice care.
- Long-term care services of relatively short duration.

- Restorative services determined to be essential to the prevention of long-term institutionalization.

By taking this approach, traditional illness services are balanced with provisions for health maintenance services which prevent illness, reduce cost, and avoid institutionalization. Thus, hospital coverage and emergency care are covered, as are such services as immunizations, physical examinations, and prenatal and perinatal care.

The creation of federal minimum standards for essential services will necessitate modifications in existing public programs. The ultimate goal will be, over time, to merge all government-sponsored health programs into a single public program.

Coverage Options
Universal coverage for the federally defined package of essential services will be accessed through an integration of public and private plans and resources.

- A public plan, administered by the states, will provide coverage for the poor (those below 200% of the federal poverty level), high-risk populations, and the potentially medically indigent. Any employer or individual will also have the option of buying into this plan as their source of coverage.

- Private plans (employment-based health benefit programs and commercial health insurance) will be required to offer, at a minimum, the nationally standardized package of essential services. This package could be enriched as a benefit of employment or individuals could purchase additional services from commercial insurers if they so choose.

All citizens and residents will be required to be covered by one of these options. Under both the public plan and private plans, no one will be denied insurance because of preexisting conditions. If employers do not offer private coverage, they will be required to pay into the public plan for their employees. Employer payments will be actuarially equivalent to the costs of employee and dependent coverage. Financial relief will be made available to small businesses (25 employees or less) for whom this provision would not be feasible. Individuals with no source of private coverage could also buy into the public plan. To assure universal access to essential services, systems

will be developed to identify the insurance option through which each individual's needs are met.

Premiums and Payment Rates
Access to health care services will be enhanced by offering insurance premiums that the public can afford and payment rates to providers that are equitable and inclusive.

Both the public and private plans will utilize deductibles and copayments to ensure that beneficiaries continue to pay for a portion of their own care and, therefore, have financial incentives to be economical in their use of services. Deductible amounts and copayment rates, however, will never serve as barriers to care. Provisions will be made to waive or subsidize deductions and copayments for households with incomes below 200% of the federal poverty level. Deductibles for certain types of programs and services (e.g., health promotion, such as well-child care, immunizations, and mammograms; and managed care plans) will be held to a minimum to encourage wider use of cost-efficient, wellness-oriented options.

Public and private payers will be required to offer fair and consistent rates of payment to providers. To protect access to care, providers will not seek payment at the point of service; nor will they be permitted to engage in balance billing. Because providers will be reimbursed fairly through insurance and the problems of uncompensated care will be largely eliminated, there will be no need for providers to charge consumers amounts above the established rate. Consequently, the consumer's financial responsibility for health care services will be more predictable.

To make insurance more affordable to individuals and to reduce costs to insurers and employers, nursing's plan calls for reforms in the private insurance market. These reforms may encompass a variety of strategies, including:

- Community rating for all insurers.
- A cap on the out-of-pocket expenses individuals must pay for catastrophic care, including nursing home and other long-term care.
- State reinsurance pools to protect insurers and consumers against the high costs of insuring a broader range of patients.

Special Programs for Vulnerable Groups
Countless individuals suffer from long-term health problems associated with inadequate access to basic health services over time. Often, the poor and many members of minority groups are in this category. Special programs will provide services and outreach to vulnerable populations in order to compensate for formerly inadequate care and its consequences.

For infants and children (e.g., low birthweight babies, battered and neglected children, pregnant teenagers, children who abuse drugs, and young victims of violence and homelessness), such programming could be viewed as a health service ("Healthstart") equivalent to the Headstart Program for those who are educationally disadvantaged. An expanded version of the Women's, Infants and Children (WIC) Program may be needed to produce quality outcomes in maternal-child health for poor and minority populations. Other special population groups also may warrant compensatory health programs beyond the scope of essential health benefits and services.

It is important to note that the ultimate goal of improved health is not achievable exclusively within the confines of the health sector. Social failures also have serious health consequences. Improvements in the broader environment have a major impact on health status and health care costs. While the focus of this plan is on the health care system, nursing's long-term policy agenda for the nation is much broader. National health reform must also consider the interrelationships between health and such factors as education, behavior, income, housing and sanitation, social support networks, and attitudes about health. Better health cannot be the nation's only goal when hunger, crime, drugs, and other social problems remain. Consequently, nursing is committed to pursuing reform in other areas affecting health. Discussion of such reform, however, is beyond the scope of this paper.

Long-Term Care
The high costs of long-term care often threaten to impoverish patients and their families. Nursing's plan seeks to prevent impoverishment and the potential loss of dignity by recognizing both public responsibility for long-term care and continued personal commitment to planning for such care. Financing arrangements will provide "front-end" coverage for chronic care and long-term care services of short duration through a variety of public and private options.

Beyond addressing short-term needs, individuals will be expected to assume personal responsibility for long-term care

through strengthened private insurance programs and a variety of innovative financing arrangements. Such strategies will include privately purchased long-term care insurance, new savings and tax incentives, and home equity conversion opportunities. Such steps are essential to prevent individuals and their families from becoming impoverished by necessary care that can be anticipated and planned for. Emphasis on personal responsibility, however, does not ignore the fact that there will always be some individuals who will be left without resources and who must reach out for public assistance.

Catastrophic Expenses
Length and/or intensity of illness may generate catastrophic costs. Given this fact, limits will be placed on individuals' out-of-pocket payments for catastrophic health care expenses. Costs to insurers or individuals that exceed preset limits will be covered through a state reinsurance pool, to which all insurers must contribute. Under nursing's plan, insurers will tap into the pool when their total costs or costs per patient exceed preset limits. When costs decline, they will resume normal financing.

Decentralized Delivery System
Although standards for essential health services and eligibility requirements are to be mandated at the federal level, delivery mechanisms for health services will be decentralized in terms of planning and administration to foster greater consumer orientation. Because local needs differ, states will have the authority to modify implementation in order to reflect geographical diversity.

To promote greater use of disease prevention and primary health care, services will be delivered, whenever possible, in convenient, familiar sites readily accessible to households and individuals. Maximizing the use of local settings, including schools, homes, places of work, and other community facilities, will help reduce the fragmentation of primary health care delivery and promote a more consumer-friendly system.

COST EFFECTIVE, QUALITY CARE

By properly balancing individual health needs and self-care responsibilities with provider capabilities, care can be provided in a more efficient and coordinated manner. It can be more effectively directed at health promotion activities that will ultimately improve outcomes and reduce costs. Nursing's plan for reform is designed to achieve such a balance.

Provider Availability
Financial and regulatory obstacles, as well as institutional barriers, that deny consumer access to all qualified health professionals will be removed. The wider use of a range of qualified health professionals will increase access to care, particularly in understaffed specialties, such as primary health care, and in underserved urban and rural geographical areas. It will also facilitate selection of the most cost-effective option for care.

Under this arrangement, health providers must be reasonably and fairly compensated for their services. Where fee-for-service payment arrangements continue, payments for patient services must be made directly to providers.

Consumer Involvement
Consumers will be encouraged to assume more responsibility for their own health. Health professionals will work in partnership with consumers to evaluate the full range of their needs and available services. Together, the consumer and the health professional will determine a course of action that is based on an understanding of the effectiveness of treatment.

Outcome and Effectiveness Measures
Development of multidisciplinary clinical practice guidelines is essential to the proper functioning of the health care system. These guidelines will be used to sensitize providers and others to the proven effectiveness of practices and technologies. With clear-cut information on the value of various procedures, payers, providers, and consumers can work together to eliminate wasteful and unnecessary services. Moreover, increased dissemination of research findings regarding health care outcomes will enhance provider and consumer involvement in making the most effective choices about care and treatment. By taking this approach, the likelihood of serious disputes or litigation over appropriateness of care will be minimized. Likewise, the need for defensive practices designed to protect providers against malpractice suits will be greatly reduced.

Practice guidelines and directives derived from research, while providing an element of control, will be supportive of innovation. Coverage will be extended to procedures shown to be significantly more effective and less costly than existing approaches, and/or useful in improving patient outcomes and quality of life. At the same time, an effort will be made to carefully weigh new therapeutic approaches with high start-up costs that may ultimately be less expensive than present methods.

Use of advancements in clinical practice and technology will be conditioned on satisfying criteria related to cost efficiency and therapeutic effectiveness. Such an approach will not deny people essential services. It will, however, carefully assess the appropriateness of providing high-tech curative medical care to those who simply require comfort, relief from pain, supportive care, or a peaceful death.

Review Mechanisms
State and local review bodies — representative of the public and private sectors and composed of payers, providers, and consumers — will be established. These groups, operating under federal guidelines, will determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. Such review will be sensitive to ethical issues.

Managed Care
Managed care will be instituted both to reduce costs and to assure consumer access to the most effective treatments. Nursing's plan envisions managed care as organized delivery systems which link the financing of health care to the delivery of services — serving to maximize the quality of care while minimizing costs. To promote the use of managed care, enrollment in approved provider networks will be a requirement for those covered by the public plan. Managed care will also be encouraged for recipients of private coverage through reductions in deductibles and copayments.

In the past, managed care has been used, in many instances, to protect the pocketbooks of insurers rather than the rights of consumers. Managed care must be restructured to retain the maximum possible consumer choice and to place a premium on services that address the health of consumers.

Case Management
In contrast to managed care systems, case management is rooted in the client-provider relationship. Case management services will be used to integrate, coordinate, and advocate for people requiring extensive services. The aim of case management is to make health care less fragmented and more holistic for those individuals with complex health care needs. A variety of health care professionals are qualified to provide this service. The first allegiance of these providers will be to their clients. Acting as advocates, they will provide both direct care and negotiate with systems on behalf of their clients. They will be authorized to access services for a given client.

Both case management (provider) and managed care (delivery systems) models are important to the smooth functioning of the health care system.

A REALISTIC PLAN OF ACTION

Under nursing's plan, universal coverage will be achieved through implementation of both the public and private plan options. Employers will be motivated to collaborate with employees in shaping private plans which best satisfy their needs. At the same time, as larger numbers of more diverse groups participate in the public plan, the attractiveness of this option in terms of cost, quality, and image will be enhanced.

While the public and private sector plans can move forward simultaneously, it may be necessary to expand coverage to segments of the population in sequential steps. These steps would be introduced at an acceptable and financially reasonable rate until the ultimate goal of universal coverage is achieved. This approach would avoid excessive shocks to the health care system and allow the public to adjust to changing patterns of service.

Given this perspective, the first targeted population would include all pregnant women, children under age six, and those individuals who demonstrate a health status seriously compromised by a history of inadequate care. Improvements in coverage and benefits for these groups will have the greatest impact on the nation's future health and productivity.

As expeditiously as possible, other segments of the population would be covered. These groups might be targeted as outlined below; this sequence, however, is not necessarily intended as a rigid order:

- All children and young people, ages 6-18.
- All those above age 18 with incomes below 100% of the federal poverty level.
- All employees and dependents.
- All those with incomes below 200% of the federal poverty level.

The process will culminate with the merger of all entitlement plans into a single public program to provide coverage to all

citizens and residents who do not have or cannot obtain coverage through a private plan.

THE FISCAL IMPLICATIONS OF REFORM

It is impossible to predict the dollar amount which will be associated with the expansion of services or the efficiencies in nursing's plan. It is predictable that additional funding will be necessary to support start-up costs and transition. It is also possible that such expenditures will be recaptured over time.

A number of proposals for reform have been introduced. Among those proposals with cost estimates, additional health care costs range from $60-$90 billion.[3, 4] While nursing's plan for expanded coverage is similar in a number of ways to some of these proposals, offsetting proposed efficiencies integral to the plan will create significant dollars for reallocation. These resources will be directed to areas currently underfunded or excluded, including long-term care and primary care services.

While precise financial estimates are not possible at this time, several general observations can be made.

Cost Impact

Extension of coverage for essential services to the uninsured and underinsured will result in the dedication of more dollars. One source estimated that such coverage, if provided in 1990, would have added approximately $12 billion to health spending.[5]

It will also be necessary to dedicate more dollars to the expansion of long-term care services. Cost estimates for improved long-term care coverage vary. One 1990 study suggests that provision of comprehensive long-term care services, if implemented in 1990, would have cost $45 billion — $34 billion of which would have been new costs.[6] Nursing's plan, however, calls for more limited coverage supported through a combination of public dollars and enhanced personal responsibility.

In the initial phases of nursing's health care reform, the emphasis on preventive services will require dollars. Over time, however, improved health resulting from the availability of comprehensive primary health care services will produce a cost-reducing "health dividend." By placing greater emphasis on health promotion and disease prevention in community-based settings, the system will reach out aggressively to individuals and households to foster an increased commitment to healthy lifestyles, prevention of disease, periodic screening for early detection of illness and earlier treatment, and promote

informed decision making by the consumer. All of this will contribute to cost-effective, early interventions which, over time, will reduce the need for more costly care.

Cost Savings
New costs associated with nursing's plan will be offset to a considerable degree by the following cost-saving initiatives:

- Required usage of managed care in the public plan and encouraged use in private plans.
- Incentives for consumers and providers to utilize managed care arrangements.
- Controlled growth of the health care system through planning and prudent resource allocation.
- Assurance of direct access to a full range of qualified providers.
- Development of health care policies based on effectiveness and outcomes research.
- Incentives for consumers and providers to be more cost efficient in selecting health care options.
- Elimination of unnecessary bureaucratic controls and administrative procedures, through such measures as standardized billing, simplified utilization review, streamlined administrative procedures, regulatory reforms, and consolidation of plans.

Sources of Revenue
To the extent that any additional dollars are needed, sources can be found. Responsibility for financing health care reform must be distributed equitably among individuals, employers, and government.

Individuals will continue to pay a portion of health costs through copayments by households and individuals with incomes above 200% of the poverty level, and through reduced copayments for those whose incomes are 100-200% of the poverty level.

Employers will provide private health insurance that meets or exceeds minimum federal standards for their employees and dependents, or will provide coverage through the public plan. Accommodations will be made to provide small businesses with the necessary financial relief to meet this obligation.

State governments currently pay a portion of health care expenses for the poor and fund certain other health programs. Nursing's health care reform plan calls for consolidation of existing government health plans into a single public program. When this occurs, all states will contribute revenues to the program through maintenance-of-effort arrangements.

Revenues to pay for any increased costs could be derived from some combination of higher tobacco and alcohol taxes, additional payroll taxes, higher marginal income tax rates, and the increase or elimination of the income ceiling for FICA tax collection. A value-added tax (similar to a national sales tax) could also be considered.

A LOOK TOWARD THE FUTURE

The existing health care system stands as evidence of the futility of patchwork approaches to health care reform. America's nurses say it is time to frame a new vision for reform — time for a bold departure from the present. Reform of any single component of the system will not do the job. Insurance reform alone will not guarantee access to care if the health care delivery system is not restructured. Conversely, many people will remain unserved or underserved if health care services are so costly that millions of Americans cannot afford to purchase care.

To be most effective, a health care system must do more than provide equipment, supplies, facilities, and manpower. It must guarantee universal access to an assured standard of care. It must use health resources effectively and efficiently — balancing efforts to promote health with the capacity to cure disease. It must provide care in convenient, familiar locations. And it must make full use of the range of qualified health professionals and diverse settings for care. It is this insight that underlies nursing's plan for reform — making it the most viable solution to the nation's health care crisis.

SOURCES

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3. *The Pepper Commission, A Call For Action: Final Report*, September 1990, p. 137.

4. Mark G. Battle, January 8, 1991, National Association of Social Workers, remarks during NASW's National Health Care Press Conference.

5. Lewin/ICF estimates, November 1990, *To The Rescue: Toward Solving America's Health Care Crisis*, Families USA Foundation, p. 13.

6. Pepper Commission, p. 151.

The following nursing organizations have endorsed *Nursing's Agenda For Health Care Reform:*

- Advocates for Child Psychiatric Nursing, Inc.
- American Academy of Nursing
- American Association of Colleges of Nursing
- American Association of Critical-Care Nurses
- American Association of Nurse Anesthetists
- American Association of Occupational Health Nurses
- American Association of Spinal Cord Injury Nurses
- American Holistic Nurses Association
- American Nephrology Nurses' Association
- American Nurses Association
- American Psychiatric Nurses' Association
- American Society of Ophthalmic Registered Nurses, Inc.
- American Society of Plastic and Reconstructive Surgical Nurses
- American Society of Post Anesthesia Nurses
- American Urological Association Allied
- Association of Black Nursing Faculty in Higher Education, Inc.
- Association of Community Health Nursing Educators
- Association of Pediatric Oncology Nurses
- Association of Rehabilitation Nurses
- Chi Eta Phi Sorority, Inc.
- Dermatology Nurses' Association
- Emergency Nurses Association
- Intravenous Nurses Society, Inc.
- Midwest Alliance in Nursing
- NAACOG, The Organization for Obstetric, Gynecologic, & Neonatal Nurses
- National Association for Health Care Recruitment
- National Association of Neonatal Nurses
- National Association of Orthopaedic Nurses
- National Association of School Nurses, Inc.
- National Black Nurses' Association, Inc.
- National Flight Nurses Association
- National League for Nursing
- National Nurses Society on Addictions
- North American Nursing Diagnosis Association
- Nurse Consultants Association
- Nurses House Incorporated
- Oncology Nursing Society
- Philippine Nurses Association of America, Inc.
- Society of Gastroenterology Nurses and Associates
- Society for Peripheral Vascular Nursing
- The Association of Operating Room Nurses, Inc.
- The Society of Otorhinolaryngology and Head-Neck Nurses, Inc.

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A Supplement to The American Nurse

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Senator SIMON. Thank you very much. Mr. Barry.

Mr. BARRY. Thank you, Mr. Chairman and members of the committee. I am Dennis Barry, president of the Moses H. Cone Memorial Hospital in Greensboro, NC. Parenthetically, Senator Simon, I was born and raised in Chicago.

Senator SIMON. Well, you are an outstanding witness.

Mr. BARRY. I am pleased to have this opportunity to be here today on behalf of the American Hospital Association's nearly 5,500 members across this country to discuss health care reform.

I have for inclusion in the record my complete statement, but in the interest of time I would like to summarize that statement.

I want to commend Senator Kennedy for his sponsorship of the health care reform legislation before your committee and has long-standing leadership on this important issue.

The American Hospital Association applauds the Democratic leadership for placing the issue of health care reform at the top of its legislative agenda. HealthAmerica is a comprehensive proposal that will help stimulate public debate on many key issues.

Those of us in the hospital field are distressed by what we see in our Nation today—growing numbers of uninsured and underinsured, deterioration in private insurance coverage, growing gaps in public programs which are creating a situation where an increasing group of citizens are seeking too little care, too late.

The consequences of these problems we see daily in our emergency departments, where we delivery tiny babies of women who receive no prenatal care and where we treat acute illness episodes in children and adults with treatable conditions that may have been prevented if we had a better system for ensuring access to care.

The news on the cost front is also grim. Health care costs, insurance premiums, unsponsored care, and government underpayments are all rising. Such a situation leads to cost-shifting, which only feeds this spiral in costs.

The strategy that the American Hospital Association proposes to address these and many other health care needs rests on a 5-part program: (1) universal coverage; (2) a single set of basic benefits; (3) a strategy to assure value; (4) a sustained commitment to biomedical and health services research, and (5) a program for meeting health manpower needs.

This proposal builds on the strengths of our existing pluralistic health care system to provide universal access. For 87 percent of the population we have perhaps the best health care system in the world, and that should not be overlooked as a starting point.

Our plan would provide universal coverage through a combination of employment-based coverage and a new single public program, consolidating and expanding Medicare and Medicaid. The employer-based approach is similar to the proposal in the legislation that we are discussing, phased in over time, with tax incentives, insurance reforms, pooling arrangements, and a small employer buy-in to the public program.

The public program would be financed through broad-based taxes and premium contributions. And, so that no American would be bankrupt by the cost of illness, we also have proposed a catastrophic coverage for all Americans as a component of the public program.

In addition, a single set of basic benefits would be defined for the public plan and would serve as a benefit floor for private health coverage or insurance plans. We envision a full range of services, from preventive care to long-term care, as part of the basic package. We believe a complete package encourages not only health promotion but also discourages inappropriate and unnecessary utilization.

Value would be assured through a number of key initiatives. These include provider accountability through the development and use of medical practice parameters, information on individual practitioner and provider cost and quality outcomes, and guidelines for the cost-effective deployment and use of new and existing health care technologies.

Providers would also be expected to coordinate care provided to patients across settings and over time. Payment incentives for different types of providers and between providers and purchasers would be aligned so that all parties work toward common objectives. Providing the same incentives for all providers is an important change if we are to ensure that providers work together toward the same purpose.

Finally, action on tort reform, the expanded use of living wills and advanced directions and changes in antitrust laws must also be made.

Finally, our plan would ensure continued benefits from medical and delivery system advances. We must sustain our commitment to biomedical research, and to ensure equal access to services, professional training programs must be maintained to assure future manpower needs will be met.

HealthAmerica is similar in philosophy to the American Hospital Association strategy I have just reviewed. We do diverge, however, on how to stimulate greater cost efficiency in the delivery of health care services in this country. We recognize that the price of universal coverage is cost control, and we believe our plan meets that challenge head-on.

We do have, however, concerns that the approach envisioned in HealthAmerica would simply restrict the dollars available to provide care. Expenditure targets and rates would be set by a new Federal Health Expenditure Board. We are concerned that such an approach would extend the current trend of health care delivery that focuses provider and regulator attention on all the wrong things—writing rules, compliance enforcement, bureaucracies, and all groups trying to shift cost and/or responsibility to someone else when faced with budget-driven limits on dollars.

Rather, as I outlined earlier, we believe reforms in this area can be achieved through a partnership with consumer and government, aimed at addressing the many underlying causes of health care cost inflation, such as alignment of provider incentives, effective managed care, development of medical practice parameters, information on individual practitioner and provider costs and quality outcomes, a structure to reconcile needs and expectations with available funding, guidelines on the cost-effective deployment and use of technology, changes in antitrust laws, and reform of the medical liability tort system.

With respect to tort reform, I would like to mention that the American Hospital Association wants to express its appreciation to Senate Hatch for his leadership in this area and his work on Senate Bill 489.

We believe the concept in HealthAmerica of State consortia for the purpose of consolidating claims processing functions is sound, and the concept of these consortia negotiating rates between small private payers and providers has some potential. However, we do have concerns over how productive such negotiations might be if the rates are precluded by nationally imposed constraints or standards.

Finally, the provision in this legislation to expand access by creating community health centers in underserved areas is especially noteworthy and should be expanded.

As I mentioned earlier, both HealthAmerica and the American Hospital Association's reform proposals are quite similar in philosophy in that both have a commitment to a pluralistic health care system. Our basic differences on how to make health care affordable clearly points to the need for greater debate and discussion. The AHA is committed to move forward with comprehensive reform of our Nation's health care system, and we look forward to working with this committee, its chairman, and the members of the committee on this very important issue.

Thank you, Mr. Chairman.

Senator SIMON. Thank you very much, Mr. Barry.

[The prepared statement of Mr. Barry follows:]

PREPARED STATEMENT OF MR. BARRY

SUMMARY

It is increasingly obvious that the cracks in the health care system are much wider and deeper than originally thought, that all segments of the population are now affected, and that we won't be able to solve this crisis unless we simultaneously, and successfully, grapple with the equally profound cost crisis. We must guarantee necessary access to basic health benefits. At the same time, we must make the changes that move our system toward improved efficiency and effectiveness so that affordability as well as quality are hallmarks. The dilemma is how to assure that costs are contained rather than shifted from one player to another, and how to assure that the hard choices about containing costs are made fairly and in the public eye rather than taking the form of de facto rationing by providers in response to payment policies.

Under the leadership of the American Hospital Association, hundreds of hospitals across this nation have spent more than a year identifying and discussing the pressing problems with our health care system, and deliberating alternative plans of action. We began with the premise that all of us—citizens, providers, insurers, purchasers, and government—will need to be part of the solution, and therefore will have to make some difficult decisions. Our resulting proposal is called *A Starting Point for Debate* because we intend it not as blueprint but as a lightning rod for comment, criticism, suggestions, new ideas and approaches. The attached testimony provides a summary of this proposal.

The American Hospital Association applauds the Democratic leadership of the U.S. Senate for placing the issue of health care reform at the top of its legislative agenda for 1991. S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act" sponsored by Senators Mitchell, Kennedy, Riegle, and Rockefeller is a comprehensive proposal that will help stimulate public debate on many of the key issues. It also is similar in philosophy to the AHA's recently developed National Health Care Strategy described in my statement, particularly in its call for:

—Universal access to basic benefits;

—Achieving that access through a partnership of the public and private sectors, building on employer-sponsored health insurance coverage combined with a revitalized public health insurance program;
—Tax incentives for employers and employees to assist their purchase of health insurance coverage;
—Insurance reform to make more affordable and reliable insurance packages available; and
—Some of the key tools needed to address structural causes of rising health care costs.

While we would approach some of these issues a bit differently, it is encouraging that the Senate democratic leadership, the AHA, and others have many bases from which to build consensus for national health care reform.

We do have a number of serious concerns, however, about S. 1227. The most significant of these is a very basic philosophical difference in how to stimulate greater cost efficiency in the delivery of health care services in this country. The approach taken in S. 1227 is a highly structured, top-down regulatory approach that restricts the dollars available to provide care. We believe this approach would perpetuate and extend the current trend of micro-management of health care delivery that focuses providers and regulators on all the wrong things: writing rules, compliance enforcement bureaucracies, and everyone trying to shift costs and/or responsibility to someone else when faced with limits on the dollars available. If we are to achieve real and meaningful reform of the health care system, we need to form a partnership among providers, insurers, consumers, and government aimed at addressing the many underlying causes of health care cost inflation. We also need to provide a structure for publicly making choices and reconciling expectations with available funding.

We look forward to working with the committee as the national debate progresses.

Mr. Chairman, my name is Dennis R. Barry, President of Moses H. Cone Memorial Hospital in Greensboro, NC. On behalf of AHA's nearly 5,500 member hospitals, I am pleased to have this opportunity to testify on the need for national health care reform, AHA's reform proposal, and our initial reactions to S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act." As a member of AHA's Board of Trustees from 1987–1990, I participated in the development of AHA's reform proposal and know how difficult it is to work through all the tough choices needed to form a comprehensive proposal. We commend you and the other sponsors of S. 1227 for your leadership and contribution to this critical debate.

The Need for National Health Care Reform

As providers of care for the insured and uninsured alike, and as advocates for the health care needs of the poor, hospitals are distressed to see growing numbers of uninsured and underinsured, deterioration in private insurance coverage, and growing gaps in public programs, because this means people will seek too little care, and will seek it too late. We see the human consequences in our emergency rooms, where we deliver the tiny babies of women who received no prenatal care, and where we attend to the acute episodes of children or adults with preventable, treatable conditions.

Particularly during the past decade, therefore, the expansion and reform of private and public health insurance coverage for the medically indigent—those characterized as "falling through the cracks" of our pluralistic health care system—has been a high priority advocacy issue for the AHA. Starting six years ago, a special committee of our Board of Trustees spent a year analyzing the problem and recommending strong reforms on both the public and the private side. As you know, we have stood before Congress on many occasions since then to urge these reforms. Considerable progress has been made, particularly with regard to the expansion of Medicaid eligibility for pregnant women and children. And these achievements have been real. Last year, the nation's infant mortality rate dropped by 6 percent—the largest amount in nearly a decade.

While these victories are heartening, I think most of us involved in the issue are far more pessimistic than we were even five years ago, because it is increasingly obvious that the cracks in the health care system are much wider and deeper than we thought, that all segments of the population are now affected, and that we won't be able to solve this crisis unless we simultaneously, and successfully, grapple with the equally profound cost crisis.

The scenario is certainly grim on the access side, and touches all of us in one way or the other:

—Thirty-three mill ion people lack health insurance entirely, and almost twice that many are intermittently uninsured. During a recent 28-month period, 63 million lacked coverage at some point.
—Many more fear that their insured status is precarious, something they could lose as a result of any number of events they cannot control—the death of a spouse, loss of a job, changes in an employer's insurance plan, or the simple deterioration of their own health.
—Many of those who do have insurance still cannot pay for needed services, because they have pre-existing conditions excluded under their policy, or because the services they need (long-term care, psychiatric care, or rehabilitative care, for example) are not covered for anyone under their plan, or (in the case of public program enrollees) because reimbursements are so low that their insurance card has little purchasing power in the health care marketplace.

The news is also grim on the cost front.
—Health care costs are growing rapidly, at a time when our GNP is not. Between 1983 and 1989, non-hospital health care expenditures grew from 6.2 percent of GNP to 7.1 percent of GNP. While expenditures for hospital inpatient and outpatient care remained relatively steady (at 4.3 percent in 1983 and 4.5 percent in 1989), expenses for all health care combined rose from 10.5 percent to 11.6 percent during this period.
—Group health insurance premiums have been increasing at an average of 16 to 18 percent a year for the past several years, and increases for many small businesses are much higher still.
—The costs of unsponsored care (care for which no payment or government subsidy was received) are rising, and reached 59 billion in 1989 for hospitals. Hospital underpayments from Medicaid are rising even more quickly, and reached about $4.3 billion in 1989.

What makes the twin problems of access and cost so intractable is the fact that they feed on each other. Unsponsored care and government payment shortfalls lead to cost-shifting. Cost-shifting fuels already-increasing health care costs, which translate to higher premium costs, followed by coverage cutbacks, which lead to more unsponsored care. Noncoverage and inadequate coverage lead to delayed care, which is also more costly.

A recent study found that one-third of indigent patient hospital admissions, other than obstetric and trauma cases, could have been avoided had the patients received primary or outpatient care in a timely manner. Unless we address the cost problem, access will continue to worsen. And the reverse is true as well.

The current health care system is a jumble of individual programs that have evolved by default, not by vision and design. Under the present system, employers, private payers, and public payers are each trying to control their own costs, most commonly by avoiding rather than managing risks, shifting costs to others, or simply limiting payments to providers. But these mechanisms do not address the root causes of rising costs, and they do not control costs in the aggregate. For this reason, we believe that no true long-term reform strategy will be effective unless it is systemic and comprehensive. We must guarantee necessary access to basic health benefits. At the same time, we must make the changes that fine-tune our system toward improved efficiency and effectiveness so that affordability as well as quality are hallmarks. The dilemma is how to assure that costs are contained rather than shifted from one payer to another, and how to assure that the hard choices about containing costs are made fairly and in the public eye rather than taking the form of de facto rationing by providers in response to payment policies.

AHA's Proposal

Hundreds of hospitals across this nation have spent more than a year clarifying and discussing the pressing problems with our health care system and deliberating alternative plans of action. We began with the premise that all of us—citizens, providers, insurers, purchasers, and government—will need to be part of the solution, and therefore will have to make changes that may be difficult to achieve.

—Individuals must accept greater responsibility for adopting healthy lifestyles. They must also use health care services efficiently and appropriately.
—Providers must eliminate unnecessary services, spurn the unnecessary duplication of costly technology, and eliminate excess capacity. Hospitals and physicians must forge effective partnerships to help bring these changes about.
—Financing and payment systems must be overhauled so that incentives support both disease prevention and care in the least costly setting.

—Insurers need to focus on risk management, rather than risk avoidance, and on keeping program administration costs to the absolute minimum. It should be the goal of the insurance industry to create mechanisms that make universal coverage affordable.
—Government must live up to its promises.

We also began with the recognition that, as a society, we need to address several hurdles to cost-effective care: the lack of consensus on the appropriate limits of treatment; unrealistic patient expectations; a medical liability climate that encourages defensive medicine; and deep-seated social problems like substance abuse, malnutrition, inadequate housing and crime, all of which impair health status and drive up health care demand and costs. Hospitals and physicians can and should exert leadership in their communities, working with other social agencies and groups to attack these problems. Our resulting proposal is called *A Starting Point for Debate*—because we intend it not as a blueprint but as a lightning rod for comment, criticism, suggestions, new ideas and approaches.

The strategy we propose as the starting point for debate has five parts: universal coverage, a single set of basic benefits, a strategy to assure value, a sustained commitment to biomedical and health services research, and a coherent approach to meeting health manpower needs. These reforms would be achieved through a staged implementation plan.

Universal coverage would be provided through a combination of employment-based plans and a new single public program consolidating and expanding Medicare and Medicaid.

—Employment-based coverage of basic benefits would be achieved in stages. First, tax and other laws would be revised to help employers sponsor coverage and ensure the availability of more affordable private insurance offerings: (1) Private health insurance would be reformed to preclude the use of preexisting conditions clauses and other underwriting practices designed to avoid rather than manage risk, (2) state laws requiring employers or employees to pay for coverage exceeding the federally defined basic benefit package would be preempted, (3) the health care responsibilities and obligations of insured and self-insured businesses would be equalized, (4) tax subsidies to support premium contributions for low-income employees would be provided, and (5) insurance through the community-rated public program would be made available to small employers (with fewer than 25 employees), the self-employed, and others unable to obtain private health insurance within their financial means.
—At the end of a specified transition period, possibly three years, any individuals unable or unwilling to obtain basic benefits coverage through the private health insurance market would be automatically enrolled in the public program when they seek services, if they do not enroll on their own. Employers would be expected to pay at least 50 percent of health care coverage costs for full-time permanent employees and their dependents and a prorated amount for part-time permanent workers and their families. The coverage provided would have to meet the minimum specifications of the federally defined basic benefit package, although employers would be free to offer more than the basic health benefit if they and their employees so desire.
—A new federal public program would be established to provide basic benefits coverage to everyone not covered by employer-based or other private plans, and to provide catastrophic coverage to everyone in the country. This program would consolidate and expand Medicare and Medicaid, covering a broader scope of services than government programs now provide, in particular long-term care and outpatient prescription drugs. It would be financed by broadly based federal tax revenues dedicated to an off-budget trust fund, plus premium contributions from enrollees who can afford them. It would be administered through regional contracts with private insurers who demonstrate the ability to hold down administrative costs.
—Catastrophic coverage would be provided under the public program for everyone, whether covered by the public or a private basic health benefits program, when required premiums and cost-sharing reach extraordinary levels compared to an individual's ability to pay.

A single set of basic benefits would be defined for the public plan and would serve as a benefit floor for private health insurance plans. To ensure access to appropriate and effective care, a full range of services from preventive through long-term care would be included and would be linked to overall cost containment goals through budget targets for basic benefits set biannually by Congress. Deductibles and copayments would apply to all services except preventive care (although they would be

eliminated or reduced to nominal levels for those with limited financial resources under the public program). A public-private commission would match the benefit package to the dollars available through the federal budget and beneficiary cost-sharing by those able to contribute. Allowable approaches for meeting the budget targets would include phasing in expanded benefits, limiting basic benefits, adjusting cost-sharing arrangements, and identifying cost-ineffective treatments to be specifically excluded from basic benefits.

Value would be ensured through health care delivery, financing, and other reforms designed to assure that care is managed and coordinated, that only appropriate and effective care is provided, and that system-wide costs are contained. As a start, we recommend changes in four areas:

—Provider accountability. All hospitals would need to continually evaluate their mission and performance from both cost and quality perspectives. In any given community, some hospitals might need to close, to merge, to consolidate specialty services, and/or to join systems or form alliances with other health care providers. Performance accountability would be built into the system through the use of medical practice parameters, wide availability of information on individual practitioner and provider cost and quality outcomes, and guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services.

—Management of care. Providers would be expected to coordinate the care provided to patients across settings and over time. Licensure and accreditation standards would ensure that, at a minimum, all facilities were linked by comprehensive referral and medical record information exchange agreements to facilitate the process of managing patient care across provider settings and to help consumers navigate the health care system more easily. Providers and purchasers would be expected to establish by contract their respective roles and responsibilities for managing care to patients within enrolled groups. A variety of arrangements for effective care management would be needed to reflect the different needs of specific, defined populations and the different delivery capacity of providers in diverse geographic areas. But the ultimate goal would be the implementation of delivery arrangements that focus on improving the health status of specific populations and deliver value when it comes to needed medical care.

—Payment incentives. Payment incentives for different types of providers and between providers and purchasers must be realigned, so that all parties work toward common objectives. New payment approaches for professional and institutional components of care need to be tested, and there is a particular need to identify and test new payment approaches which make purchasers' incentives and objectives compatible with those of providers with whom they contract. For example, purchasers and providers in a region might share each year any overall financial gains or losses incurred in serving a defined population enrolled under a particular arrangement for management of care.

—Climate for cost containment. Affordability of needed services would be strongly advanced by reform of the medical liability tort system to obviate the need for defensive medicine; by widespread use of living wills and other advance directives to improve patient self-determination and limit non-beneficial final care; and by changes to antitrust law and other legislative and regulatory barriers to effective cost-containment.

A sustained commitment to biomedical and health services research would help ensure that all Americans continue to benefit from medical and delivery system advances. Biomedical research enhances our capacity to diagnose and treat illness; health services research is essential for more complete information on such critical issues as assessing the efficacy of diagnostic and therapeutic regimens and establishing the relationship between treatments and outcomes. Health system reform must include support for innovation and the evaluation of new approaches.

A coherent and comprehensive approach to meeting health manpower needs also must be adopted in the United States if we are to realize the goal of adequate access to health care services for everyone. Public policy decisions at the national, state, and local levels and local training program decisions should all work toward the central goals of adequate supply, efficient use of health care professionals, and appropriate geographic distribution of needed health manpower. Actions designed to deal with these issues should be based on sound assessments of manpower needs and should focus on both the near term and the future.

Our proposal contains a series of recommendations designed to achieve these goals by providing for:

—regular and comprehensive national assessments of future health manpower needs;
—incentives to attract qualified students to the health professions;
—the stabilization of existing training programs, promotion of new programs where needed, and reorientation of training programs to future needs;
—greater career mobility within health care professions;
—the elimination of barriers (particularly regulatory barriers) to the efficient use of health care professionals; and
—incentives to attract and retain health care professionals in poor, remote, or underserved areas.

Implementation would be staged. The changes we envision are extensive, and would have to be carefully phased in. We propose step-by-step implementation of the proposal to minimize disruption in current coverage patterns and to facilitate the introduction of broader benefits. Starting with mothers and children, coverage of the poor and the near poor who are not currently covered by Medicaid should be provided by the public program over a pre-established period of time, as cost savings from the system reforms outlined above are added to other available revenues. Those able to pay their own way should be added to the public program if they are unable to obtain basic benefits coverage in the private sector.

As new benefits are added, such as outpatient prescription drugs and long-term care, current public program participants, as well as new enrollees with incomes exceeding 150 percent of federal poverty guidelines, should contribute, with premiums, deductibles and copayments scaled to ability to pay. Only in the final implementation stage, and only if anticipated reform savings fall short, would increased contributions for services that now are subsidized be sought from current Medicare beneficiaries who are able to contribute.

Staged implementation also provides the opportunity to deal with major transition issues, such 'as the Medicare trust fund, and realigning state and local government responsibilities as the federal government assumes responsibility for the public health care coverage program.

As you can see, AHA's overall approach is to build on the strengths of our existing pluralistic health care delivery and financing systems to enhance access by everyone to affordable, quality health care. Health care in a country as culturally diverse as ours is very much a local affair; what makes sense in some communities may be infeasible or ill-advised in others. Pluralistic financing facilitates local control over health care delivery, permitting variations based on area resources and priorities. Moreover, while the administrative costs of a pluralistic system of financing might be higher than a monolithic system such as Canada's, a pluralistic system spurs innovation and enables health care costs to be spread among individuals, business, and government, rather than concentrated as a burden on one funding source.

AHA's proposal calls on everyone to contribute to reform, but it also provides benefits for everyone.

Consumers would be responsible for greater cost-sharing, either paid out-of-pocket or through private supplemental coverage until catastrophic limits are reached. They may also find their choices narrowed somewhat by arrangements to manage care. In return, however, they would gain financial access to a full range of coordinated medical services, from preventive to long-term care, sharply reducing today's difficulties in obtaining needed care and the confusion that can accompany negotiating our current system. Delivery system incentives would focus on keeping them healthy, and no one would be impoverished by health care bills.

Employers would be responsible for contributing toward basic benefits coverage for their permanent employees and their dependents, but they would have much greater access to affordable health insurance. All employers would be treated equitably under tax and insurance laws. Tax incentives, hardship funds, and other subsidies would ease financial pressures of coverage. The hidden tax many businesses now pay to cover care for the uninsured and underinsured would drop dramatically as more and more corporations help underwrite insurance coverage for their employees and the government pays its health care bill in full.

Practitioners and health care facilities would be accountable for treatment outcomes on both cost and quality grounds. Information on provider cost and quality performance and adherence to technology diffusion guidelines would be used by at least some purchasers in making selective contracting decisions. Medical practice parameters would be used by third-party payers as payment screens. To be eligible to contract with purchasers, providers would have to accept an appropriate share of the financial risk associated with the cost and utilization of services. Hospitals and physicians must forge effective partnerships that lead to the elimination of excess capacity, of duplicative and underused technology, and of unnecessary or ineffective

care. At the same time, health care facilities would see a major reduction in uncompensated care over time, would be fairly paid for the care they deliver, and government, purchasers, and the public would join health care providers in making difficult access choices when resources are inadequate to cover all services.

Private insurers would be required to change certain underwriting practices, and face competitive pressure to keep administrative costs down and premiums affordable. At the same time, they would have broader opportunities to market affordable basic benefit and supplemental insurance packages, to compete without negating the purpose of insurance through carefully constructed insurance reforms, and to administer an expanded public program.

Government would be expected to meet its obligation to ensure coverage for all those unable to do so themselves and to become a trustworthy partner in the financing and delivery of health care. At the same time, assisted through cost sharing by beneficiaries who can afford it and a more accountable health care delivery system, government would be better able to live up to its promises.

All purchasers would be expected to pay their own way without cost shifting, but all would achieve greater value for their health care dollars. They would have ready access to soundly developed medical practice protocols, guidelines on appropriate use of technology and special services, and information on the cost and quality of care delivered by specific providers.

S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act"

The committee asked that we comment on S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act" sponsored by Senators Mitchell, Kennedy, Riegle, and Rockefeller.

The American Hospital Association applauds the Democratic leadership of the U.S. Senate for placing the issue of health care reform at the top of its legislative agenda for 1991. S. 1227 is a comprehensive proposal that will help stimulate public debate on many of the key issues. It also is similar in philosophy to the AHA's recently developed National Health Care Strategy described in the rest of my statement, particularly in its call for:

—Universal access to basic benefits;
—Achieving that access through a partnership of the public and private sectors, building on employer-sponsored health insurance coverage combined with a revitalized public health insurance program;
—Tax incentives for employers and employees to assist their purchase of health insurance coverage;
—Insurance reform to make more affordable and reliable insurance packages available; and
—Some of the key tools needed to address structural causes of rising health care costs, such as:
  —stimulating outcomes research and the development of medical practice parameters to foster effective clinical decision-making and sound judgments about the appropriateness of care;
  —making available information on provider and practitioner cost and quality outcomes and guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services to support greater provider performance accountability; and
  —reform of the medical liability tort system to obviate the need for defensive medicine.

While we would approach some of these issues a bit differently, it is encouraging that the Senate democratic leadership, the AHA, and many others have many bases from which to build consensus for national health care reform.

We do have a number of serious concerns, however, about S. 1227. The most significant of these is a very basic philosophical difference in how to stimulate greater cost efficiency in the delivery of health care services in this country.

The approach taken in S. 1227 is to establish a Federal Health Expenditure Board that would set national expenditure goals in total, for specific segments of the health care industry, and for states and regions. The Board would then negotiate with representatives of providers and purchasers to establish rates "and other methods" (presumably capacity and volume restraints) to achieve the goals. If those negotiations were successful, the rates and other measures would be binding on private payers except in those states where state purchasing consortia chose to go beyond their required function of consolidating claims processing to develop alternative payment methods that meet the state expenditure goals set by the Board. After

eight years, AmeriCare (the new and expanded Medicaid), would be required to come up to Medicare payment rates for all services. Over time, Medicare would be expected, but not required, to achieve rates comparable to those set by the Board. If the national negotiations were not successful, the Board would issue advisory rates for use by state purchasing consortia and individual payers.

This highly structured, top-down regulatory approach restricts the dollars available to provide care. We believe this approach would merely perpetuate and extend the current trend of health care delivery that focuses providers and regulators on all the wrong things: writing rules, compliance enforcement bureaucracies, and all groups trying to shift costs and/or responsibility to someone else when faced with arbitrary, budget-driven limits on the dollars available. If we are to achieve real and meaningful reform of the health care system, we need to form a partnership among providers, insurers, consumers, and government aimed at addressing the many underlying causes of health care cost inflation. We also need to provide a structure for making choices and reconciling expectations with available funding.

An important aspect of this approach is the creation of incentives for everyone involved—providers, insurers, consumers, and government—to get at and change the behaviors that contribute to rapidly escalating health care costs. An incentives approach to provider cost containment requires a structure within which individual performance matters. In other words, varying rates and regulatory oversight on the basis of how well and to what extent each provider manages patient care and costs. We are concerned that regulatory structures like the one found in S. 1227 can often result in rates that do not have the flexibility to reflect qualitative differences among providers or the services rendered.

Furthermore, we believe S. 1227 should include provisions to align the incentives among providers, or between providers, insurers, and their subscribers or beneficiaries. Without such incentives, we will perpetuate the conflicting provider incentives of paying hospitals on a per-admission basis while paying physicians and other practitioners on a fee-for-service basis. Health care reform legislation should attempt to bring provider, insurer, and subscriber incentives together by promoting risk-sharing arrangements that focus on maintaining and improving the health status of covered populations so that their need for expensive health care services is reduced. By severely limiting allowable out-of-pocket expenditures for copayments and deductibles to very low levels, there would be little incentive for consumers to be prudent in their use of services or to enter legitimate managed care programs. It would be far better to provide for higher levels of income-sensitive copayments and deductibles so that these incentives would be created and the savings could be used to fund a broader range of benefits, which would also help physicians and care managers better match services to patient needs.

The issue of promoting "managed care" requires a special note. We support managed care, but we are concerned by the increasing degree to which Congress, insurers, and employers define managed care simply as a system of selective provider contracting and/or external utilization review. This is not managed care, it is managed cost. While mechanisms to manage cost are not inherently bad, we should not lose sight of the limitations of such mechanisms and the potential effect on patients when external review entities are focused solely on minimizing cost.

Many so-called managed care programs in operation today do nothing to assess or manage the health status of enrolled populations. They often do nothing more than enforce external utilization review, which can impose the discipline of cost-consciousness, but can also increase administrative costs, inappropriately interfere with physician-patient relationships, and cause patient distress over improperly denied health insurance claims. S. 1227 seeks to promote managed care by limiting state efforts to regulate abusive external review and other practices. But giving free license to external reviewers does nothing to promote the true management of care, which should focus on the overall efficiency and appropriateness of health care delivery.

True managed care requires a broader, longer term focus on improving the health status of enrolled individuals and controlling medical care costs while ensuring quality. Managed care means assessing patient needs, and then planning and organizing care so that all needed services are efficiently provided and care is coordinated over time and across providers. Moreover, because managed care should seek to improve the general health status of its enrollees, it should be concerned with all aspects of care, including promotion of preventive services and the long-term management of chronic illness. Of necessity, that requires the development of delivery arrangements, such as HMO's, that bring clinicians into much stronger partnerships with health care managers in order to achieve effective patient care management.

AHA supports true management of care and we believe it can be accomplished through a variety of models, but we believe such arrangements should be promoted in a way that will encourage management of health status and coordination of care. Furthermore, such arrangements should be promoted by providing incentives for their formation and for consumer selection of them, not by exempting them from state laws containing basic consumer protections. Consequently, we urge an expansion of the bill's approach to managed care.

AHA also believes that the federal government has an obligation to remove key barriers to cost containment initiatives. Chief among these is the need to reform the application of federal antitrust law and redirect the efforts of the federal antitrust enforcement agencies: the Federal Trade Commission (FTC) and the Department of Justice (DOJ). That view is strongly held by our members. The most recent issue of Hospitals reports that in a survey of 250 hospital CEO's, 91.6 percent said the federal government should relax antitrust laws to allow hospitals in a market to combine services. We were pleased to find that S. 1227 recognized the antitrust issue. But the limited exemption for providers to form together to negotiate rates with the state purchasing consortia, and then only if the resulting rates remained consistent with federally set targets, should be expanded.

Throughout the country, hospitals (particularly those in communities with two or three hospitals) are locked in key battles with FTC or DOJ over whether they can merge or combine certain services within the community. The federal enforcement agencies' success in frustrating mergers and other forms of community-based collaboration has had a chilling effect on efforts to bring health care providers together to eliminate duplicative and often costly services to make more efficient use of the community's resources. Even for those whose projects survive antitrust challenges, the cost of fighting the battle is often overwhelming. Consequently, many opportunities for cost containment and the more efficient use of capital resources are being lost. For providers to cope with increasingly stringent constraints on available health care funding without damaging the quality of care provided and to avoid the unnecessary duplication of health care technology, we must have the ability to work together at the community level without requiring elaborate and time consuming regulatory oversight mechanisms to shield such efforts from FTC antitrust challenges.

Finally, we believe the concept of state consortia for the purpose of consolidating claims processing functions is sound, and we would like to pursue further discussions about the approach. We all need to seek ways to reduce the crushing burden of administrative costs. The concept of those consortia also negotiating rates between small private payers and providers has some potential as well, but not if the rates or payment levels are dictated from the national level. Under such a top-down approach, engaging the state consortia in negotiations would probably not be productive since true negotiation would be precluded by the nationally imposed constraints. We also believe it would be inappropriate to mix state regulatory functions (such as capital allocation) into such consortia.

There are several more specific and sometimes technical comments on S. 1227 which we would be happy to share with the committee.

Conclusion

There is a growing consensus among providers, employers, insurers, and others that the twin crises of access and costs cannot be solved separately. Both S. 1227 and AHA's reform proposal join the two issues of health insurance coverage and health care costs. They also share the philosophical commitment to a pluralistic health care system. Our basic difference—how to make health care affordable—and the degree of philosophical difference represented by these two proposals, clearly points to the need for greater debate if we are to form the national consensus needed to achieve reform. AHA and its members are committed to that task.

AHA's strategy was offered as a starting point to stimulate discussion and debate. Our objective is to continue throughout 1991 to shape the Starting Point into a workable proposal for reform that has a broad base of support. By early 1992, the AHA Board of Trustees expects to reach closure on all major modifications and/or expansions. We look forward to working with Congress in the months and years to come in achieving a long-term health care strategy to address the critical issues of access and cost.

Senator Simon. Thank you very much, Mr. Barry.

Mr. Bromberg.

Mr. Bromberg. Thank you, Mr. Chairman.

I will try to summarize briefly our testimony and not repeat what others have said this morning to the extent I can. But I would be somewhat remiss if I did not take the opportunity to express our gratitude to Senator Kennedy for his leadership on this issue over the years, and his continuing leadership at a time when we need it, to get the issue on the national agenda. While we may disagree with parts of the bill and have to devote a lot of our testimony to those disagreements, we do appreciate his efforts and the efforts of his cosponsors and other colleagues to get this issue higher up on the national agenda, because it does need to be addressed.

I would like to talk a little bit also about some of the areas of consensus that I think exist which, if we could just focus on, we might make some progress instead of spending another 50 years debating some of the ideological and political and partisan issues that divide us, because there are areas of agreement.

With respect to our problems with the bill, pages 3 and 4 of our testimony basically list them. I'll just very briefly make a couple of statements that aren't in the testimony.

I can't help but look at you, Mr. Chairman, and remember that Senator Simon so articulately and eloquently led the fight for years here against draconian budget cuts from OMB on Medicare, sponsoring amendments on the Senate floor, fighting tooth and nail the fact that this administration seemed to be looking at health care as a budget only and not as a policy. And yet, I want to try to warn you and your colleagues that you are going to walk into a much bigger trap if, instead of giving OMB $100 billion to play with in health care, to downgrade as a priority, if you in a single-payer system or in any other kind of approach that gives the government too much power over $700 billion, you'll have to be seven times as effective and articulate on the floor of the Senate. That's our major concern, with the fact that cost control should not be done, in our opinion, by direct government regulation. But it needs to be done, and I'd like to get to that in a minute.

Some of the other things we are concerned about in this bill obviously are the track record of all-payer rate-setting, which we have some testimony and studies we have referred to here—we don't think they solve the problem. We think they are going to get in the way of the one solution that has the most promise, which is managed care. We are unhappy about costs ourselves. You've got to remember that hospitals employ four million people who are watching our wages go through the roof, our supply costs and everything else. And we look at a bill that talks about ceilings, caps and price controls, but never mentions controls on wages or supplies that we buy.

Believe me, hospitals wish their costs were less, and yet this bill seems to be a one-sided way of getting at prices without looking at underlying costs at all. We are worried about technological improvements. We are worried about how in the world some Federal board or government would take a national expenditure target and allocate it among 50 States, and we try to imagine the political nightmare that would ensue as Senators try to protect their States and get more money for theirs on the grounds that maybe they

started with a lower base. And on and on. I'll skip over that and try to get to what we are in favor of.

We think there are two major problems in the system. The first one is the safety net is broken, clearly. The Medicaid program is supposed to, in the minds of the public, cover the poor; it only covers 40 percent of those under the Federal poverty line. It covered 60 percent of them 20 years ago. Something has gone wrong. If the government can't manage that program and fix it, we're not ready to give them the whole health system. But I think that is the top priority. We've got to do something about the poor and strengthen that safety net. That's partially a budget problem, but it is also a structural problem.

We think the Medicaid program ought to be abolished and made into a Federal program like Medicare, or it ought to be Federalized, or at the very least, the Congress ought to put Federal minimum standards under it so certain States can't do what they are doing, particularly in the South, which is putting ridiculous income eligibility standards and payment levels under the program.

The second major problem is the 15 million or more Americans out of that 33 million who work for employers who don't provide insurance. Many of them are small employers. There has been a lot of work done in the Congress and in the industry, and you will hear from subsequent witnesses, a lot of agreement on small employer health insurance reform.

Senator Durenberger has a bill, and there are several other bills in. It seems to me that one of the dangers I heard this morning was talking about we need major comprehensive reform, not minor incremental reform. Well, there is something in the middle called major incremental reform.

There are many things that could be done that don't cost any money, that could help millions of people, that could be done this year or next year instead of waiting for this increasingly more partisan debate to unravel over the big picture. Small employer insurance reform is one. Malpractice reform is another. Encouraging managed care is another. There is a laundry list of other cost control provisions—State mandates, anticompetitive State laws. I could go on and on and give you 10 or 12 things that are in the Mitchell-Kennedy bill that we support strongly as cost containment measures.

There are a lot of things going on in the private sector. In our testimony we list some case studies of what business can do to control costs. I won't cover that now or try to. I just want to skip to two more issues.

One, there are two ways to control health care costs in this country. One of them, we support, and there are lots of ways to do it; the other one, we oppose. I want to give you the difference.

We will support any cost containment device that is geared at getting at the Rand Corporation's studies and what the witnesses before us talked about, which is eliminating unnecessary, ineffective, inappropriate, wasteful care. Whether that be the acceleration of treatment guidelines, whether it be encouraging more managed care, etc., we'll be for it.

Now, how do you get there? I think that the fastest way to change behavior in America is clearly the tax code. It has been

proved time and time again that changes in the tax code lead to quick changes in behavior, and I think a cap, some kind of ceiling on the amount of health insurance that is going to be excluded from income, will send a very strong signal to people—employers, employees and insurers—that people want to buy managed care programs that can come in under that cap.

If you want to accelerate the trend to managed care, if you want to accelerate the trend toward stopping unnecessary care, there is no better way to do it than through the tax code. There are other ways to do it that we support as well, which we list here, such as treatment protocols, etc., but the one that will do it the fastest because it sends an economic incentive signal quickly is the tax cap.

The other way to do it is direct government regulation and price controls. You have heard the arguments from business against it; they are in our testimony, and I won't bore you with it again.

I just want to close with a comment about the political stalemate that has gone on for 50 years over this subject. In part it is centered about the role of government. We have a trust problem with government, we in the health care industry. We really do. We have been burned under Medicare. Promises have been broken. Programs have been underfinanced. Medicaid has been underfinanced. Every time the government has gotten its hands on a health program, it has underfinanced it. The only thing that has saved the quality of care from deteriorating in this country is the unfair cost shift.

Yes, it is unfair, but without the cost shift, that was the only safety valve we had left. Our concern is how to cut costs without putting all the money in the control of the government.

My other concern clearly is that it would be tragic if this debate, which is becoming increasingly partisan—and I am frustrated by it, as you can hear, and I don't like it—health care should be a bipartisan issue. It has been in the past. Something has happened in the last year to make it partisan. And if we have to wait until 1993 to make it bipartisan again, we'll have to wait for the big one, but in the meantime I think you ought to look at some incremental reforms that can be passed before 1993, many of which are in the Mitchell-Kennedy bill, many of which we support. There is no reason to wait to help the millions of people who would be helped by some of those reforms.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Bromberg follows:]

PREPARED STATEMENT OF MR. BROMBERG.

Mr. Chairman and Members of the Committee, my name is Michael D. Bromberg and I am Executive Director of the Federation of American Health Systems, the national association which represents investor owned health systems. Our members include more than 1,400 hospitals as well as integrated health plans which insure several million Americans.

We appreciate the invitation to appear before the Committee to comment on health policy issues and S. 1227, the "Health America: Affordable Health Care For All Americans Act." Members of the Labor and Human Resources Committee have played an important role in the current debate on how to improve our nation's health care system. The Federation has worked with you Mr. Chairman in seeking to broaden the access to health insurance benefits for our nation's employed population and their dependents. Senator Durenberger has introduced several bills offering solutions to critical issues such as small employer insurance market reform. Senator

Hatch has been a leader in the search for meaningful reform of our present medical liability system.

We applaud Senate Majority Leader Mitchell, Chairman Kennedy and Senators Rockefeller and Riegle for taking the initiative in assuring that needed health care reform takes its rightful place at the top of our nation's priorities.

However, we are deeply concerned about their proposals to place the federal government at the center of so many important spending decisions governing health care. A health care system in which government controls prices and sets budgets will lead, inevitably1 to serious shortfalls in quality and access.

We support many of the cost control provisions in the bill, such as increased managed care and health outcomes research and the use of treatment protocols, because these are aimed at eliminating unnecessary, ineffective and inappropriate treatment.

On the other hand, we strongly oppose the two provisions which would establish national "voluntary" expenditure targets or caps and require negotiations of all payer rates and the creation of state consortia which could also negotiate prices and volume of services.

These provisions are anti-competitive and unfair to hospitals because they would not set caps on wages which comprise more than half of hospital costs or limit the cost of supplies hospitals must purchase.

Technological improvements would be stifled by a ceiling on expenditures.

Geographical allocation of the national expenditure caps would be a political nightmare because of existing variations in quality and per capita spending among the states.

All payer rates would also stifle the growth of managed care and other innovative financing and delivery systems as evidenced by the much lower penetration of HMO's in rate setting states.

While the bill talks about voluntary caps and negotiations, it represents a giant step toward the type of Canadian and European controls which have rationed the availability of new technologies and created waiting lists for services Americans demand and expect.

Price controls in other sectors of the economy, such as rent controls and oil price controls, when tried, have produced a decline in the quality and variety of the products or services and an absence of consumer choice.

Health care is the second largest industry in the United States, employing nearly ten million people, about four million of them in our nation's hospitals.

The health care delivered in America is the finest in the world for those who have access to it and can afford to pay for it. The vast majority, 87 percent, of Americans are insured or covered by health plans. For these individuals there are no waiting lists; they have access to the best trained health professionals in the world, the latest in medical technology and outstanding facilities. The system has serious problems, however, and those problems are increasing at an alarming rate. Access and affordability gaps in the system are the two major issues which need to be addressed.

Problems in our Health System

About 60 percent of Americans living below the federal poverty line are not eligible for Medicaid, up from 40 percent twenty years ago. That gap must be eliminated or substantially narrowed if America is to claim to have a national policy in health care. We believe a federal policy is needed to assure access and financing for this population group. We support federalization of the Medicaid program—or at least federal minimum standards for Medicaid eligibility, benefits and payment for services.

Fifteen million or more Americans work for employers who do not provide insurance. Most of these people work for small employers who do not have access to large group coverage and affordable insurance rates. A myriad of state laws mandating services which must be covered in health insurance plans present a real obstacle to small employers seeking affordable coverage for their employees. We support efforts to enact small employer insurance reforms as a first step to expand adequate employment based coverage of needed medical and mental care for all Americans who work.

Uncompensated care provided by hospitals has grown from about $3 billion in 1980 to about $10 billion in 1990. Investor-owned private hospitals provide uncompensated care which exceeds five percent of their revenues. Private payers, employers, and other health plans are increasingly unwilling to cross-subsidize indigent care costs or the shortfalls from reduced Medicare or Medicaid payments.

Costs continue to increase for providers as well as consumers and payers of health care services. The major obstacle to cost containment is the lack of incentives for selecting cost effective coverage. The federal tax code provides exactly the wrong incentives by treating all employer purchased health insurance as an exclusion from income. This perpetuates the notion that the right to health care carries with it little responsibility for cost containment on the part of those using the system.

Private Initiatives

There are encouraging signs in the business community that managed care plans, which emphasize utilization review and appropriate levels of care, hold much promise for cost containment through the selection of quality1 cost conscious providers and the use of quality based protocols for treatment. If the tax code were amended to place reasonable limits on the amount of tax exempt insurance purchased by employers, those managed care plans would be in greater demand by employees and employers alike.

In recent months employers have become more serious about getting better value for their health care dollars. There is growing evidence that their efforts can be effective. A recent study by Jack Meyer, health care economist at New Directions for Policy, describes a number of case studies in which employers are making a difference as prudent purchasers of care.

Allied Signal, using a plan developed by CIGNA, experienced a four percent increase in health costs in 1989 compared to a 39 percent rise in 1987. Allied estimates its 1989 costs were 20 percent less than they would have been under the previous plan.

Using a Prudential point of services plan, Southwestern Bell—whose per employee costs had been growing at a 20 percent annual rate—lowered the increase to well under ten percent in 1989. Proctor & Gamble, with a similar plan established by Metropolitan, lowered its annual rate of increase from 15 percent to a little over six percent.

These "point-of-service" plans offer employees a choice of reduced, little or no cost sharing if they use network physicians with the freedom to go outside the network if they pay significant amounts of their own money, usually 20 percent of the costs after a higher deductible.

Southern California Edison maintains ten in-house clinics that operate as managed care systems handling over 100,000 patients per year and other companies such as Chevron have established national managed care programs for mental health and substance abuse services based on the network approach.

These types of managed care programs would proliferate if the tax code incentives were restructured to reward cost effective purchase of health coverage. In addition to creating the incentives for cost effective health plans, a limit on the tax exclusion for health insurance also would generate the revenues to expand coverage for those most in need. Health is the only fringe benefit which is not capped and a small fraction of the approximately $50 billion in lost revenues from the tax exclusion could subsidize care for the neediest segment of our population.

Lower income employees could also be exempted from such a change in the tax code to assure a fair and equitable redistribution of the tax subsidy for private insurance.

The Case Against Government Cost Controls

Some states have tried rate controls on hospitals for more than a decade, but they do not have a better record in controlling costs than states which have relied on market forces. For example, per capita hospital spending in the four largest rate setting states (Maryland, Massachusetts, New Jersey, and New York) grew at an average annual rate of 8.1 percent over the 1985–88 period while the market-oriented states of Minnesota, California, Delaware and Colorado experienced a 7.1 percent average growth rate. The national average growth rate during those years was 7.8 percent. (Lewin/ICF Analysis of Hospital Expenditures and Revenues, February 1990.)

Hospital operating margins in the regulated states averaged 0.4 percent during the period 1984–1988, while margins in the four market-oriented states averaged 5.6 percent. The margins in the rate setting states are clearly inadequate to assure that the physical plant and equipment of hospitals will be kept up-to-date.

Federal controls on total health expenditures substitute government power for consumer decisions and discourage improvements in quality and value. Research and development of new medical technologies and delivery systems would be inhibited. Providers would have little incentive to participate in managed care networks

once their rates for all payors were set. Price controls without controls on wages or supplies would be unfair and would drive down operating margins already at dangerously low levels. The process of distributing health care dollars among states as well as providers would raise serious political and geographic issues. Low cost states and lower cost providers might find their revenues capped despite greater need to improve the quality of care while more influential but higher cost providers use political skills rather than relative performance to influence the rate commissions which control the health care dollars.

In a recent speech, Mr. Powell Woods, Vice President for Human Resources at Nestles in Cleveland, makes this point from the view of a large purchaser of health care. He said:

—"... No organization was ever controlled or regulated into efficiency, but many have been managed into efficiency with well designed, properly implemented incentives. And this is exactly what market reform is. Market reform is simply payers agreeing to purchase the highest quality medicine they can find at the most efficient (competitive) price that they can find it."

Managed care distinguishes between needed and unnecessary medical treatment. Government expenditure controls focus on budgets, not the necessary costs of quality care.

In addition, we support expansion of current efforts to develop medical treatment protocols based on health outcomes research. This important educational tool is important for both providers and consumers in their health care decisions. The President's budget calls for only a $7 million increase in the budget of the Agency for Health Care Policy & Research, an amount we believe should be substantially increased.

In summary, the Federation believes it is time to strengthen the world's best health care delivery system by enacting reforms designed to provide access to that system to all Americans and to inject incentives to make that care affordable.

Time for a National Policy

It is time for the United States to spell out a national policy on health care coverage for all its citizens. We do not advocate government control of all health expenditures. In fact, we believe such a system would deprive consumers of the choices which make up one of the great strengths of the current system. If a deficit ridden, insolvent government takes control of all health spending, quality and access will suffer as arbitrary, budget driven controls on spending are imposed. Innovation and research and development of new technology would be curtailed and consumers would be the big losers in a government controlled system.

Government does have a major role to play, however. Only government can remove some of the obstacles to competition and cost-containment by reordering incentives such as the ones we have discussed here today. Government also has a responsibility to the disadvantaged and should act as a payer of last resort for needed coverage.

The major faults in our present system include the open ended tax subsidy for employee health benefits which encourages spending without any restraint and the lack of government coverage for over ten million poor people at the same time we subsidize or spend nearly $150 billion on health care for middle and upper middle income Americans through Medicare and the tax code. Until these two major issues are addressed, gaps in affordability and access will remain threats to the very strengths of the current system which we ought to be preserving.

As frustration over access and costs increases, we need leadership in developing a national health policy which preserves the strengths of the current system and solves its very real problems. If that leadership is not forthcoming soon, the rising frustrations could lead us into a system in which government rather than consumers make decisions about rationing and allocating resources based on arbitrary budgets rather than need. (Attached to our testimony is a summary of our proposals for a national health policy).

Summary

We believe that the United States needs a national health policy which assures access to all Americans, finances that care for those unable to payl and provides incentives for cost effective health plans. Consumer choice must be preserved because choice and managed care hold greater promise for cost containment than government expenditure caps or rate controls. We support changes in the tax code to limit tax free employee benefits in order to create incentives for cost effective, man-

aged care plans. We also support acceleration of efforts to develop treatment protocols based on health outcomes research to eliminate unnecessary care, use of pooling techniques to provide access to affordable coverage for small employers, malpractice reform and expansion of public programs with federal minimum standards to cover all people living below the poverty line.

The "safety net" in health care is not working as well as it should because the Medicaid program has not met its promise to provide care for the poor. The fact that only about 40 percent of those living in poverty are now eligible for Medicaid compared to 60 percent ten years ago proves this program needs to be strengthened. We support federalizing the program, but in lieu of that, we support federal minimum standards for state eligibility, benefits and payment levels.

Family values and responsibility in health care must include appropriate cost sharing. The Administration's plan for imposing higher Medicare premiums on high income families deserves serious consideration. We would support taxation of the value of the Medicare benefit as a more equitable approach to reflect ability to pay for services and to partially finance a national health policy.

The concept of paying for coverage rather than separate services should be considered as a way to improve efficiency in the Medicare program. The new entrants to the program each year should be viewed as a logical national demonstration group for this purpose. For example, Medicare could allow each new entrant to voluntarily opt to continue the private insurance or health plan coverage they have had during employment with Medicare contributing a fixed amount toward the premium or cost of that plan. This would test the concept of buying coverage instead of services on a purely voluntary basis. Another idea worth testing on a demonstration basis is whether beneficiaries would accept a high lifetime or annual deductible in return for broader catastrophic coverage under Medicare including a long term care benefit.

For fifty years or more we have debated the issue of national health insurance. Political and ideological differences over the appropriate scope of government's role have brought is about a stalemate. If progress on the interrelated issues of access, cost and quality is to be made, we need to focus on the areas of consensus and forge a bipartisan alliance. There seems to be a consensus on small employer insurance reforms, malpractice reform and increased access for the poor. I believe the health community is ready to work with Congress to take a major step toward establishing health policy reforms. We cannot support a government controlled, single payor system for the reasons stated above, but we can and do support efforts to encourage appropriately managed care to contain costs and assure quality.

We appreciate this opportunity to appear before the Committee and our industry is willing and anxious to work with you on steps to improve the American health system.

National Health Policy

The American health care system needs to provide universal access to quality care at a reasonable cost. The Federation of American Health Systems believes that progress toward these goals requires the following:

(1) A cap on the amount of employer paid health insurance that is tax free to the employee; these revenues should be used to finance the increased costs of an expanded Medicaid program. Purpose: To restrain demand and establish incentives for lower cost health insurance plans.

(2) Expansion of employment-based private insurance coverage. Employers should offer a minimum benefit package to their employees, or in the alternative, to pay a tax on wages paid. Early retirees, self-employed, and all others under age 65 not covered by insurance would be subject to a "buy insurance or be taxed" requirement with tax credits for small employers.

(3) Medicaid reform: federal minimum standards for Medicaid eligibility, benefits, and payment for services; gradual conversion of Medicaid to a program that subsidizes private health insurance plans with subsidies related to income, and a buy-in option for the unemployed and uninsurable regardless of income.

(4) Federal pre-emption of state mandatory benefits laws, and the substitution of a national minimum benefits package.

(5) Repeal of state laws banning limitations on patient freedom of doctor or hospital choice.

(6) Gradual conversion of Medicare to a program with private insurance options. and immediate expansion of Medicare demonstration projects to test preferred provider (PPO) and other insurance options. To ease the burden on private payers,

Medicare payment rates should be derived not by government fiat, but by competition among health plans.

(7) Taxation of the actuarial value of the Medicare benefit, with an exemption for low income beneficiaries.

(8) Research, development, and dissemination of data for developing medical practice protocols, to increase quality and reduce unnecessary services.

(9) Study of the desirability of federal government re-insurance (catastrophic stop loss) for all Americans.

(10) Federal malpractice reform such as limits on contingent fees for plaintiff attorneys and limits on punitive damages and awards for pain and suffering.

Senator SIMON. Thank you, Mr. Bromberg. Dr. Todd.

Dr. TODD. Thank you, Mr. Chairman.

I am Jim Todd, and I am the executive vice president of the American Medical Association.

The introduction last month of HealthAmerica into the U.S. Senate marked an historic event. It signalled that the time for action on the health care system reform is now, as well as the serious intent of this committee, its chairman, and other Senate leaders to forge reform.

On behalf of the American Medical Association, I commend your efforts. This is indeed a bold initiative.

We agree with many elements of the bill, but—not unexpectedly—we have some concerns with some others. We are impressed by some of the new thinking in the bill, with concepts such as a National Health Expenditure Board, challenging us all to reassess our view of the future of the American health system.

Many of the provisions of HealthAmerica would establish an increased role for the Federal Government in health care delivery. In some areas this increased role is necessary to assure that all have access to coverage and reasonable rates.

Quite frankly, this raises some concerns among physicians who are not convinced that they can rely on fair administration. Past experiences with the Medicare program and the current problems with the implementation of the Medicare physician payment system indicate that this anxiety and concern are not unjustified and will not be easily overcome.

The tremendous importance of HealthAmerica is the momentum that it adds to the reform agenda. HealthAmerica and the AMA's reform proposal, Health Access America, share the common fundamental goals of broadening access, improving quality and controlling the costs of health care. My formal statement for the record reflects the association's preliminary reactions.

The AMA strongly concurs with the HealthAmerica concepts of requiring employment-based health insurance and assisting businesses to comply with this requirement. We would provide this assistance not through a residual public program, however, but through a series of significant measures designed to help employers purchase private coverage. The incentives include small group insurance market reform, replacement of State benefit mandates, and financial and tax incentives for new and small businesses.

Purchase of private coverage avoids creating another large governmental health bureaucracy; it avoids the perception that enrolling employees in the public program would be to the financial or administrative benefit of the employer, and it avoids disruption of

efforts to reform the private health insurance market, especially as it relates to the small group market.

The concept and details of a Federal Health expenditure Board are extremely complex, yet specific problems do not detract from the creative nature of this approach. The creation of such a board is probably the most innovative concept in HealthAmerica. The board could, like the Federal Reserve Board does for banking, help set the agenda for the future of the US health system, and this concept certainly merits further development.

Especially important is that for the first time negotiation is envisioned, rather than a "command and control" approach. For any negotiation process to be meaningful, each party must have a degree of leverage. A true negotiations process should be carried out on both the expenditure goals and the means of implementing these goals. It is also essential that any board include physician representatives and that the process overall represents a true opportunity for negotiation and compromise and not a "take it or leave it."

The AMA also supports measures that reduce administrative costs without compromising the quality or the availability of care. The optimal consortium functions, though, are troublesome.

For example, the AMA is interested in proposals to reduce inappropriate expenditures on capital or technology, but we are concerned if this is an effort to revive the ill-fated health planning program repealed by the Congress. Similarly, the meaning of encouraging a rational distribution of health care providers is unclear.

The time for the study of the professional liability issue has long since passed. Prompt reform is essential to reduce the significant cost and access problems associated with unrestrained medial liability.

In fact the AMA believes that the viability and credibility of any health system reform proposal hinges upon the inclusion of significant liability reform. And we strongly support S. 489 introduced by Senator Hatch and urge its inclusion in any reform proposal.

Under HealthAmerica the Federal Health Expenditure Board would develop quality goals, and each State would create a Quality Improvement Board to review the quality of care provided in that State. The AMA strongly supports the enhancement of quality in health care, but we question, however, whether the establishment of 50 QIB's, the addition of another layer in the health care bureaucracy, is the most appropriate way to ensure high-quality care and whether alternatives such as licensing boards could assume many of the anticipated functions of the QIB's.

We also find the certification concept intriguing. As you know, physicians and other providers are reeling from the hassle factor in medicine today. We anticipate the profession would welcome a mechanism that allowed providers who fall within certain parameters a degree of freedom from the virtually incessant review activities of third parties.

In summary, we see HealthAmerica as a positive step in the pursuit of health system reform. It is a thoughtful and complex proposal worthy of serious consideration, and we welcome the opportu-

nity for discussion and hope that our insights will be helpful to you.

We look forward to continuing dialogue on this issue.

Thank you.

[The prepared statement of Dr. Todd follows:]

Prepared Statement of Dr. Todd

Mr. Chairman and Members of the Committee: The introduction last month of the "HealthAmerica" bill in the United States Senate marked an historic event. It signaled that the time for action on health system reform is now. Debate and study alone no longer are acceptable responses. It signaled the serious intent of this Committee, its Chairman and other Senate leaders to forge reform. On behalf of the American Medical Association (AMA), I applaud your leadership in the health system reform movement, and commend your efforts. This is a bold initiative.

The AMA appreciates the opportunity to be here today to discuss HealthAmerica. We agree with many elements of the bill. We disagree with some, and need further explanation of many others. We are impressed by some of the new thinking in the bill. Concepts such as a National Health Expenditure Board challenge us all to reassess our view of the future of the American health system.

Many of the provisions of HealthAmerica would establish an increased role for the federal government in health care delivery. Frankly, this raises some concerns among our members who are not convinced that they can rely on fair administration. Past experiences with the Medicare program, and the current problems with implementation of the Medicare physician payment system, indicate that this anxiety and concern will not easily be overcome.

The tremendous importance of HealthAmerica is the momentum that it adds to the reform agenda. The bill offers a credible proposal that merits the scrutiny of all participants in the reform process. We hope that those participants who have proposals will study HealthAmerica and compare it to their own plans, as the AMA is doing. We also hope that those without proposals will come forward, join the debate and facilitate development of a solid reform package.

HealthAmerica and the AMA's reform proposal, Health Access America, share the common, fundamental goals of broadening access, improving quality and controlling the costs of health care. My comments about HealthAmerica, which reflect the Association's preliminary reactions, will be directed at these goals.

I. ACCESS TO HEALTH CARE FOR ALL AMERICANS

HealthAmerica would expand access through the "pay or play" concept. Employers that do not provide private insurance coverage for their employees would pay a percentage of payroll to "AmeriCare," a new federal public insurance program. The employer contribution would be set at a level that would encourage private coverage, and the benefits essentially would be the same under the public and private options.

The "pay or play" model has received much favorable attention since its endorsement by the Pepper Commission. Proponents of the model note that it provides employers who cannot afford private insurance a means of ensuring employee coverage without risking financial ruin.

The AMA strongly concurs with the HealthAmerica concepts of requiring employment-based health insurance and assisting businesses to comply with this requirement. We would provide this assistance not through a residual public program, however, but through a series of significant measures designed to help employers purchase private coverage. The incentives include small group insurance market reform, replacement of state benefit mandates with a more affordable essential benefits package and financial and tax incentives for new and small businesses.[1]

We believe that enabling employers to purchase private coverage is preferable to creating a new federal insurance program for three reasons. First, we question the creation of another large governmental health bureaucracy. Large programs such as Medicare tout low administrative costs, but the provider community has found that program costs and "hassles" are merely projected onto their ledgers and into their

[1] Health Access America also would expand the Medicaid program, support state risk pools and require the self-insured to contribute to risk pools. Many of the HealthAmerica measures designed to implement small market insurance reform and otherwise assist new and small businesses are consistent with the measures contemplated by Health Access America.

practices. Large governmental bureaucracies historically have not been efficient. They have been subject to budget-driven administration that has often placed dollars before quality or accessibility. We question whether the outcome would be different for a program such as AmeriCare, and, if not, whether working Americans would accept that approach.

Second, there is a perception that enrolling employees in the public program always would be to the financial or administrative benefit of the employer. Financially prudent employers, therefore, would have the incentive to choose the public option even if they could afford private coverage. If this occurred, the AmeriCare program would swell with enrollees, ultimately draining government resources.

Third, unrestrained entry into a federal program could disrupt reform of the private health insurance market, especially as it relates to the small group market. If the federal program became the dominant mode of providing employment-based coverage, the private insurance market would have little incentive to respond to the current pressure for reform, or to seek innovations on a continuing basis. Thus, the market could stagnate, the risk-avoidance practices of many companies could continue, and employers would be further discouraged from purchasing private coverage for their employees.

These concerns might be alleviated by specific bill language requiring the percentage of payroll to be maintained at a level that would not induce a large influx into the public program. Careful oversight and administration of entry into the public program also would be helpful.

II. COST CONTAINMENT

The Federal Health Expenditure Board

HealthAmerica would create an independent agency within the executive branch called the Federal Health Expenditure Board. The Board, which would have 11 members, is intended to "fairly represent" the interests of health care providers. A majority of the Board would be experts in health care issues and would "fairly represent the interests of the general public in having access to quality and affordable health care."

The Board would have many responsibilities, most notably including: (1) developing national health care expenditure, access and quality goals; (2) convening and overseeing negotiations between health care providers and purchasers "to develop payment rates and perform other activities necessary to achieve expenditure goals;" (3) establishing recommended payment levels and other recommended measures such as increased utilization of managed care and allocation of capital; and (4) establishing uniform billing and claim forms and mandatory reporting requirements.

As we understand it, the Board would develop a goal for total health expenditures in the US, and for each state and region. The Board would consider relevant factors such as inflation and demand, and allocate the goal to discrete sectors such as hospital services, physician services and laboratory services.

The Board then would convene negotiations between purchasers and providers to determine the terms and conditions related to providing health care within the expenditure goals. The Board would adopt the negotiating process to be followed. Negotiations would be held for each service sector, and could at the Board's discretion be conducted for sub-sectors. Negotiators would attempt to agree on recommendations to be submitted to the Board regarding a health care payment system (which would be based on Medicare payment unless the Board decided otherwise) and uniform payment rates that would achieve the expenditure goals.

The Board would determine the institutions. individuals and organizations that would be eligible to represent purchasers and providers at the negotiation table. Generally, a potential representative would submit a petition identifying the organizations or individuals that it represents in a particular sector. If at least 25% of the providers or purchasers in a sector chose that representative, it would be approved as a negotiator. If at least 50% of the providers or purchasers in a sector chose that representative, it would be the exclusive negotiator for that sector. If, in a given sector, health services were primarily delivered through institutions or organizations, the Board would establish an election procedure that would be based on a weighted designation of all the institutions and organizations according to their revenues or patient load.

The bill contemplates the following three outcomes to the negotiations process.

—If the negotiators agree to recommend to the Board a proposal about a rate structure or "any other matter" that would lead to achievement of the expenditure goals, and the Board concurs that the recommendation will achieve the

goals, the Board would promulgate regulations implementing the rates and other matters, all of which would be binding in the sector involved.

—If the negotiators reach agreement "concerning a goal that is different than a goal that has been developed by the Board," the Board would adopt the negotiators' goal if the Board determines that doing so would be in the best interest of the general public. If the Board rejects the negotiators' goal, the Board request the negotiators to reach agreement on the original goal, and promulgate regulations recommending rates and other matters to achieve the original goal.

—If the negotiators fail to reach agreement on a goal, the Board would promulgate advisory rates and other matters to achieve the goal.

The concept and details of a Federal Health Expenditure Board are extremely complex. The primary impediment to understanding the Board and its functions is that the bill language is at times unclear and inconsistent. Several examples follow.

—The bill states that providers would be fairly represented on the Board. It also states that the majority of the Board would represent the interests of the public. What is the meaning of "fairly represented?" Given the bill's broad definition of the term "provider," is it possible that the provider representatives on the Board might not include physicians?

—Giving the Board the power to establish the negotiations process and to determine the individuals or institutions that are eligible to negotiate gives the Board broad power over the process and the players.

—The actual content of negotiations is unclear. At times the bill states that the negotiations will address the "rates and other matters" necessary to reach the goals. At other times, the bill implies that negotiations will address the goals themselves.

—The outcome of situations where the negotiators agree to a rate system (or goal) that the Board rejects is unclear. If the Board requests the negotiators to return to the table, and the negotiators still disagree with the Board's goal, what is the outcome? Are the "recommended" rates that the Board promulgates binding? If not, who sets the rates? Similarly, if the negotiators reach no agreement and the Board promulgates "advisory" rates, is there any consequence to not adopting those rates? Is it acceptable in that situation for everyone to set their own rates?

—What is the result if binding rates are promulgated and followed, but the expenditure goal is exceeded?

—The procedure for appointment as a negotiator is unclear. What if one representative had the endorsement of 50% of the providers, which would warrant appointment as the exclusive negotiator, and one had the endorsement of 25%, which also would warrant appointment?

—What if the Board decided to break the sectors into sub-sectors? Could there potentially be negotiation with each medical specialty and sub-specialty, or with geographic sectors of physicians?

The creation of such a Board is probably the most innovative concept in HealthAmerica. The Board could, like the Federal Reserve Board for banking, help set the agenda for the future of the U.S. health system. The concept merits further development, including the addition of safeguards to prevent federal micro-management of health care delivery and ensure that the views of participants are fairly represented.

The degree of uncertainty surrounding this process prevents a thorough analysis or any conclusions on our part. For any negotiations process to be meaningful, each party must have a degree of bargaining power. A true negotiations process should be carried out on both the expenditure goals and the means of implementing those goals. It is essential that the Board include physician representatives, and that the process overall presents a true opportunity for negotiation and compromise—not the "take it or leave it" scenario that exists in some countries that negotiate health budgets.

Managed Care (Including Utilization Review)

HealthAmerica strongly promotes, but does not mandate, the use of managed care. For example, the bill would guarantee the employee the right to choose a non-managed care option if he or she is willing to pay up to 200% of normal cost-sharing. In addition, to assist small employers, the bill would require carriers that offer managed care in a community to offer that option to all small employers in the same community. The bill also would preempt virtually all state regulation of managed care and utilization review.

What effect the bill would have on future developments in managed care is unclear, but three entities that HealthAmerica would create the Federal Health Expenditure Board, state purchasing consortia and state quality boards—apparently would have the authority to increase the development and use of managed care. In addition, states would, as part of their administration of AmeriCare, provide for managed care. Finally, the Secretary would, as part of AmeriCare, provide grants to states for demonstrations of cost-containment initiatives that involve the use of managed care.

The AMA always has supported management of care, which traditionally has been done by individual physicians on a case-by-case basis. With the advent of heightened cost-consciousness, "managed care" has proliferated, and become attenuated to the degree that it now encompasses broad activities that consume significant resources. Management of care, which includes utilization review (UR), no longer is reserved for individual physicians, but frequently is performed by third parties who have no contact with the actual patient or physician under review.

The AMA believes that managed care as it exists today is an alternative that should be available in a pluralistic health system. We oppose mandatory managed care, and arrangements that effectively foreclose the use of non-managed care through unreasonable financial penalties.

Our support of the availability of managed care options has several caveats.

—*We urge caution in adoption of unproven management or review procedures that may exact more hassle. time and quality costs than the save.* Many management procedures designed to eliminate waste have had the opposite effect. For example, the use of second surgical opinions, once heralded as a great cost-saver, has largely been discontinued as a cost-containment device. In addition, some observers have noted that the alleged savings due to inpatient UR are negligible.

—*Those who implement managed care—the reviewers—must be qualified and accountable for their actions.* At a minimum, the following standards should apply: (1) any physician whose services are being reviewed for medical necessity should be provided the name of the reviewing physician on request; (2) reviewing physicians who make judgments about the medical necessity or appropriateness of care should be of the same specialty and licensed in the same jurisdiction as the physician under review; (3) reviewing entities should be subject to legal liability for harm to the patient or physician caused by the entity's conduct; and (4) medical protocols and review criteria should be developed by physicians.

—*Review entities and health plans that use review strategies have a disclosure obligation to patients and providers.* Review or management entities should disclose upon the request of the provider the review criteria, weighting elements and computer algorithms, along with information on how they were developed. Health benefit plans also should disclose to prospective enrollees in clear and simple terms the benefits provided, coverage limitations and review or management requirements.

—*All health clans that conduct review or management should be responsive to patient and provider inquiries and problems.* Specifically, the plans should establish a process for meaningful review of adverse determinations, including the right to review by an independent physician of an adverse coverage determination. Also, plans should respond to prior authorization requests in two days, and other medical necessity inquiries within one day.

—*State laws regarding managed care and utilization review offer vital protections to providers and patients, and should not be preempted by federal law.* Many states have passed laws that protect the rights of providers and patients who participate in managed care plans. These laws typically guarantee that all qualified providers are free to contract with managed care entities, that providers and patients receive complete information and that review is conducted in a manner that is fair to both providers and patients.

State Purchasing Consortia

HealthAmerica would require each state (or region) to establish a consortium of every in-state health insurer that has a small market share. The consortium would process all the claims of member insurers, and, therefore, achieve administrative savings through economies of scale. In addition to its "superprocessor" function, the consortium would develop uniform billing and claim forms and procedures, establish a paper less processing system that includes the use of "smartcards" and achieve other administrative savings.

"Optional" functions of the consortium would include convening negotiations with providers, purchasers and others about coverage, reimbursement and other matters, developing capital allocation procedures and collecting data on providers that would be disseminated to consumers to facilitate choice of providers and encourage efficient provider behavior.

The AMA generally supports measures that increase administrative savings without compromising the quality or availability of care. We support the concept of allowing states to demonstrate health reforms, such as the cost control demonstrations that the bill contemplates. We believe strongly that new cost-containment reforms should be demonstrated on the state level, with the active involvement of state medical groups, before they are mandated at the federal level. The "optional" consortium functions are troublesome by definition and by their vagueness. For example, the AMA is interested in proposals to reduce inappropriate expenditures on capital or technology, but we are unable to assess the bill's cryptic reference to capital allocation. Is this an effort to revive the ill-fated health planning program repealed by Congress? Similarly, the meaning of encouraging a rational distribution of health care providers is unclear. We also find the vague reference to provider data collection and distribution troubling. (See related discussion under the heading Quality Improvement Board.) Medical Liability Reform

HealthAmerica would provide grants to states to develop and implement liability reforms, and authorize the Institute of Medicine or a similar independent entity to study the liability issue and recommend reforms.

The time for study of the liability issue has passed. Prompt reform is essential to reduce the significant costs and access problems associated with unrestrained medical liability. In fact, the AMA believes that the viability and credibility of any health system reform proposal hinges in part on the inclusion of significant liability reform measures.

The AMA strongly supports the liability reforms contained in S. 489, the "Ensuring Access Through Medical Liability Reform Act of 1991," that was introduced early this Congress by Senator Hatch. The fundamental liability reforms contained in S. 489—capping noneconomic damages at $250,000 or less, providing for periodic payment of future damages, offsetting collateral source benefits, limiting suspension of the statute of limitations for minors and regulating attorney contingent fees on a decreasing index—have already been proven to work in California. They are an essential component of broader reform.

Perhaps the most alarming aspect of the liability crisis is the effect it has had on the physician/patient relationship. Once grounded in trust, this relationship has become clouded with suspicion and finger-pointing. Physicians have come to view their patients as potential plaintiffs, and patients have been encouraged to believe that anything less than a miracle is malpractice.

Medicine cannot guarantee miracles. Yet, as the recent Harvard Medical Practice Study concluded, medicine's record is very good; patient care was found to be safe and free of negligence in at least 99% of all hospitalizations. What medicine wants is revision of the liability system to encourage realistic expectations and reduce the need for defensive medicine. When trust is restored to the physician/patient relationship, both parties will be able to work together more effectively to increase positive health outcomes.

Outcomes Research and Practice Guideline Development

HealthAmerica would seek to control costs through continued support and development of practice guidelines and outcomes research. It also would support technology assessment as a "quality" measure.

The AMA supports the development of practice parameters, and believes that appropriately developed parameters will enhance the value of health care by helping to eliminate ineffective treatments and services. We have been a leader in the development of parameters, and are working with the Agency for Health Care Policy and Research on this important issue. The AMA has formed two working groups—the AMA/Specialty Society Practice Parameters Partnership and the AMA/Specialty Society Forum—to guide and coordinate parameter development and examine the complex issues involved in the process.

A prime example of the beneficial effect parameters can have is found in the guideline for the use of cardiac pacemakers that was developed by the American College of Cardiology in 1984. In the 1960's and 1970's, indications for the use of pacemakers varied. The College responded to this by coordinating development of clinically relevant parameters that identified the appropriate use of pacemakers. The guidelines were welcomed by the profession, and the utilization rate for pace-

makers decreased from 2.44 per 1,000 Medicare beneficiaries in 1983 to 1.76 per 1,000 in 1988—an approximate 25% reduction.

The AMA also supports outcomes research and technology assessment. These activities can achieve substantial cost savings and quality enhancement by assessing the effectiveness of medical treatments. The AMA devotes significant resources to technology assessment through its Diagnostic and Therapeutic Technology Assessment (DATTA) program. Since 1982, DATTA has been evaluating the safety and effectiveness of drugs, devices, procedures and techniques used in the practice of medicine. DATTA draws from a panel of 2,500 expert physicians who evaluate new and emerging technologies. The results of these assessments are communicated to practicing physicians and more than 1,150 health care organizations, primarily through AMA publications.

Additional Cost-containment Measures

Additional cost-containment measures that the AMA supports include replacing state benefit mandates with an essential benefits policy in the employment context, amending the federal antitrust laws to permit fee review by local medical groups, health promotion and providing incentives to reduce inappropriate health care consumption.

III. QUALITY

Under HealthAmerica, the Federal Health Expenditure Board would develop quality goals to improve the quality of the US health care system, and implement an extensive data collection system to amass data on particular providers. Each state would create a Quality Improvement Board (QIB) to review the quality of care provided in the state and implement the data collection process in conjunction with the Expenditure Board. Seven of the 15 QIB Board members would represent providers.

The QIB would have the four following functions:

(1) adoption of guidelines for appropriate medical practice and for measures to improve provider quality (the guidelines would include those developed by the Agency for Health Care Policy and Research and could include those developed by professional societies);

(2) recommendation of measures for continuous quality improvement, such as continuing education requirements and, for institutions, internal quality improvements (to be developed in conjunction with the Joint Commission for Accreditation of HealthCare Organizations (JCAHO), associations and professional bodies);

(3) certification of providers as "outstanding," based upon (i) conformity to guidelines, (ii) scientifically valid measures such as health outcomes, and (iii) adoption of measures recommended for continuous quality improvement; and

(4) data collection on providers for ultimate distribution to consumers to empower consumers to compare providers based upon quality and cost.

The AMA strongly supports enhancement of the quality of the health care delivered in this country. As stated previously, we have been very involved with the development of parameters. We support states' efforts to enact reasonable quality measures, and believe that appropriate data collection can be invaluable in measuring such things as outcomes.

We do not believe, however, that establishment of 50 QIB's—the addition of another layer in the health care bureaucracy—is the most appropriate and efficient way to ensure the delivery of high quality care. State licensing boards, which already exist, could assume many of the anticipated functions of the QIB's. Moreover, the relationship between QIB's, Medicare Peer Review Organizations, the JCAHO and other "quality" organizations is unclear. We believe that creation of 50 QIB's may increase administrative costs significantly and unnecessarily.

We are troubled by the bill's suggestion that QIB's could disregard use of guidelines developed by entities other than the AHCPR. The AMA supports and works with the AHCPR. We believe, however, that the medical profession must have significant involvement with the development and use of all medical guidelines. State and specialty medical societies have the ability to draw from the experience of their members, and in that respect are more attuned to the changes in practice than a federal agency.

We find the data collection and dissemination activities of the QIB's quite disturbing. The AMA supports data collection, and believes that this activity may, when it

has been fully developed and refined, provide valuable information. We also believe that the goal of helping consumers make educated health care decisions is laudable.

The "art" of health care data collection and interpretation. however. is in its infancy. There is a perception that we can simply collect data, draw conclusions and "rate" providers. The innumerable variables involved with medical care—complicating medical factors, patient behavior, the intervention of other health care workers—however, prevent easy analysis of data. Even the highest quality care does not always result in a cure.

Data collection works well in computing baseball batting averages. We simply do not have the capability to use health care data to provide reliable score cards for physicians.

A good example of how misleading health care data can be is found in the recent—and controversial—release of hospital mortality data. It has not been shown to assist consumers and, in fact, has caused much confusion. We think a much better approach would be to provide the data to the providers, who can use the information to improve their practices if necessary. When quality is a problem, provider education has been shown to be far more effective than punishment.

Finally, we find the certification concept intriguing. As you know, physicians and other providers are reeling from the "hassle" factor in medicine today. We anticipate that the profession would welcome a mechanism that allowed providers who fall within certain parameters a degree of freedom from the virtually incessant review activities of third parties. In fact, we have long asserted that because most physicians provide high quality care at appropriate levels, review resources should be focused on areas with demonstrated problems. This alternate approach also would facilitate quality efforts while decreasing the hassle factor for the majority of physicians.

Our concerns with the certification concept include the definition of the term "outstanding," which is unclear from the bill. What would be done to assist providers who might not meet the definition, but in fact are exemplary providers? Would providers not labeled as "outstanding" be subject to express or implied penalties? When a provider has had problems, we strongly encourage educational intervention, and not penalties.

CONCLUSION

HealthAmerica is a positive step in the pursuit of health system reform. It is a thoughtful and complex proposal that, like the AMA's proposal, addresses the accessibility, cost and quality of health care. We will continue to study and evaluate the bill's bold initiatives.

We welcome the opportunity for discussion with this Committee, Mr. Chairman, and hope that our insights have been helpful to you. We encourage continued dialogue among all reform participants, for it is only through collaboration of the private and governmental sectors that we will achieve optimal reform.

Senator SIMON. Thank you.

I have three questions from Senator Kennedy for you, Dr. Todd, and I am just going to read those questions, and then I have some other questions for both you and the other members of the panel.

Dr. Todd, some people say that we should make some modest incremental changes such as Medicaid expansions and small business insurance reform and see what happens, before we move to a program that would actually assure every American basic coverage.

What do you think of that position?

Mr. Todd. Well, Senator, in many respects incrementalism is in the eye of the beholder. Clearly, the time has come to make some changes in our system, and as Mr. Bromberg suggested, there are those that can be made immediately, but they are only part of the pie that needs to be baked in getting health care system reform in this country.

If incrementalism is the only way that it can be accomplished, it is better than no movement; but in our view it is time to make the major changes and fix all of the problems at a single time.

Senator SIMON. Dr. Todd, through a good part of its history the AMA strongly opposed any governmental attempt to guarantee that every American would have private health insurance coverage. Why has the AMA changed its position?

Dr. TODD. Senator, I'm not sure the AMA has changed its position that it wants to give the entire health care system to the Federal Government to administer. On the other hand, situations have changed, times have changes, imperatives have changed, and it would be irresponsible for an association that represents the physicians of this country, trying to care for patients, not to recognize a role for the Federal Government to do for those who cannot do for themselves.

Health care has become so expensive because of new technology, changing demography and greater ability to care for patients, that there is a segment of our population that is going to need significant help if they are going to be able to achieve the miracles of modern medicine.

We believe that there is a role for government in all of this. We hope that the government would take the lead in trying to push the dialogue forward, and we want to be a part of that.

Senator SIMON. Then the final question from Senator Kennedy: Dr. Todd, I was pleased to see that you felt that the concept of a Federal Expenditure Board merits further development, although you expressed a number of legitimate concerns. Obviously, there are a number of technical questions raised in your testimony that would need to be worked out.

Stepping back from those technical questions, what are the two or three primary concerns about the board that need to be addressed in order for doctors to support it? Could you support it if these conditions are met?

Dr. TODD. Well, first of all, we would want to be absolutely sure that this expenditure board and its negotiating process would be true negotiations. So often in the past we have had to deal with regulatory agencies, congressional committees, present our testimony, and have no idea what is going to happen when we walk away from the table and have to watch.

For this board to have credibility with the profession and the patients they serve, it has to be an objective, true negotiating session.

Second, the selection of representatives to negotiate with the board. As we look at the language in the proposal, if 25 percent of a sector sign on, then they will be approved as a negotiating unit. If 50 percent of a sector sign on, then it becomes an exclusive negotiating group.

Does this mean that we may have 79 medical specialty societies and at least three different categories of hospital associations negotiating, or is it going to be possible to get the professions in a firm and solid negotiating understanding with their members?

Then third, what happens if agreement is not reached? Does it continue as it was? Do we have to go back to further negotiations? Or does the board supersede and just publish its regulations and be done with it?

Let me also say one of the reasons that we are intrigued by the concept of an expenditure board is that the health care profession in all respects has been whipsawed because of overvalued proce-

dures, capital expenditures and the like, and this says to us that there may be an opportunity to return some degree of predictability into health care financing. For that reason, we are willing to pursue the concept even though we do have some concerns about it.

Senator SIMON. On the matter of if there cannot be an agreement reached, would you favor some mechanism for binding arbitration?

Dr. TODD. Not really. It would seem possible if we collect the appropriate information—and we heard a lot about data this morning—if we had the right data, it would seem to me that it would be possible for the negotiators and this board to reach a reasonable conclusion. Nobody is going to get everything they want, but an understanding of the needs and the moneys involved.

The other thing that has to be taken into account, and one of the dangers of this board, is that they would only look at money. We do not believe that the health care expenditures in this country are going to be lessened or brought under control just by looking at issues of reimbursement. There are many other areas that need to be taken into account. Everyone who has testified this morning has testified about the need to do something about professional liability.

We also need to do something about public perception. Even licensing boards now are forcing physicians into perhaps providing some care that they might choose not to if they weren't under that constraint.

I think the public is telling us something in the rush to develop living wills, durable power of attorney. I think they are telling us that in some instances may be we are giving too much health care. So that anything that deals with control of health care expenditures has to look at more than just money. It has to look at social philosophy, it has to look at medical science, it has to look at professional liability and reach a conclusion as to what is the appropriate level of care that is being given that will indeed benefit the patients.

Senator SIMON. Mr. Bromberg talked about the shifting of health care costs, and there is no question that is happening. Mr. Barry is very much aware of that. The Federal Government, through Medicare paying 84 cents on the dollar, is shifting that cost to the private patient. Medicaid in many instances, including the State of Illinois, is even worse.

As I understand your Health Access America you would Federalize Medicaid, and you talked about that, Mr. Bromberg. I would be interested in hearing from all four witnesses whether you favor Federalizing Medicaid in some way.

Ms. Redman.

Ms. REDMAN. The American Nurses Association does believe that we will eventually need to pull together all Federal programs into one program with a standard set of benefits defined and that this is necessary to get control of quality and cost.

Senator SIMON. Mr. Barry.

Mr. BARRY. The American Hospital Association would support the same proposal, and our strategy does recommend that Medicare and Medicaid be combined and consolidated and expanded into one program.

Mr. BROMBERG. We would certainly support the same. The only comment I would make is that I think it was Morris Abrams who once had an ethical report submitted to President Carter that contained a quote—and I don't have it exactly—but he said something about the fact that it was immoral for a country to spend something like four times as much on people who can afford to pay for their health care as they do for those who can't afford to pay. And what he was referring to is the same issue I touched on before about the tax cap—in America right now, we spend $105 billion on Medicare. We spend almost that much on Medicaid, and we spend another $50 billion subsidizing through the tax laws employer-paid insurance, 80 percent of which goes to people who make more than $30,000, so that at least they are not poor.

The only means-tested part of that is Medicaid, and it means the Federal Government is spending 4 to 5 times as much subsidizing the nonpoor as it is for the poor. So I would stress that when we say we want to Federalize the Medicaid program, we want to do it to target the people who really need it and not necessarily open it up to people who don't necessarily need it.

My fear would be that we would have so many employed people opting into it because they can't afford the "pay or play" provision, and I'd want to look at it closely. But if it is truly for people under the Federal poverty line, they should be covered.

One last point. Twenty-five percent of all uninsured people in America are children. That's a startling statistic. Going back to your incremental question, your first question, Medicare was an incremental reform, Medicaid was an incremental reform. If we can't do it all in the next year or two or three, maybe we ought to look at that population of children who make up 25 percent of the uninsured. That would be a pretty good incremental reform if we could cover them somehow in a Mitchell-Kennedy type bill. It is a compromise worth thinking about if we can't do it all by the year 1993.

Senator SIMON. Dr. Todd.

Dr. TODD. Yes, the American Medical Association favors the Federalization of Medicaid, with a uniform benefit package, uniform eligibility throughout the country, and also covering everyone at the poverty level or below.

We share Mr. Bromberg's concern that the government should only do for those who cannot do for themselves, and those who can care for themselves should.

Senator SIMON. Mr. Bromberg, as to your comment about the partisan nature of things, I hope we can move to a bipartisan effort. But sometimes the great steps forward we make in this Nation are partisan. Social Security didn't receive a single vote from one political party. I hope we can have a bipartisan approach.

The phrase that you used more frequently than any other in your testimony was "managed care". What do you mean by "managed care"?

Mr. BROMBERG. Well, we've been looking at a lot of definitions of it in the last week. Managed care basically is a system in which there are economic incentives for the use of efficient, cost-effective providers. There is all sorts of managed care. Hospitals like to think they manage care, and I hope we do. Individual providers manage care. But we are talking about the financing and delivery

of it. We are talking about—and I hate to step on the next witnesses' area, because I don't know as much about insurance as the next two witnesses do—but I think there is a revolution going on in the health insurance business in this country. It is a revolution that has begun, and it is becoming very clear, and it is that insurance companies are no longer just going to pass claims through—they are going to start questioning what is necessary, what is unnecessary, what is inappropriate. And the best way to do that is not on a claim-by-claim basis, but by having networks of providers who are efficient and who practice quality care at a reasonable cost.

Group practice medicine is another example of managed care. The Mayo Clinic is one example. Kaiser is another example. But so are PPO's and managed care networks. Blue Cross has many of them. I think in the State of California, Blue Cross is almost 90 percent managed care and only 10 percent fee-for-service now.

American corporations have found—there is the Allied Signal example, the Southwestern Bell Prudential example, and there are a dozen case histories cited in one of the studies that have been done by Jack Meyer—American business has found that using its market power, it can reduce its rate of growth by encouraging its employees to go to these networks, but still leaving them the point of service option of going to any doctor they want at a deductible, let's say, of 20 or 30 percent, or a copayment of 20 or 30 percent.

There is all sorts of experimentation going on, and I think a narrow definition would not serve well for a trend that is still evolving, but that's basically the gist of it.

What it has in common with the other proposals we supported, like treatment protocols and malpractice reform, is the objective of it and the economic incentives of it are to eliminate unnecessary, inappropriate and ineffective care by choosing providers who do that—quality providers. Quality is really the key to it. But I think it has a tremendous cost containment advantage, and I think more of it would happen if we changed the tax laws, and I think more of it is going to happen as employers realize they have to do it.

The only argument I have ever heard against it—I have heard two; one, I don't understand, that it is a one-time savings. That just isn't true. Some of these deals are 3- and 4-year deals that companies are signing, so it cannot be a one-time saving. The other one I have heard against it is that if a small number of employers do it and cut a deal for themselves, it is going to cause a cost shift to everyone else.

Well, there are Federal programs like Medicare that could do more with it, and private corporations could be given—employees as well as employers—a much stronger incentive to consider it if the tax laws were changed.

Senator SIMON. Mr. Barry, Senator Kennedy has three questions we will submit to you in writing, and if you would respond in writing, we would appreciate it.

Mr. BARRY. OK.

Senator SIMON. Senator Wellstone.

Senator WELLSTONE [presiding]. Thank you, Mr. Chairman.

Let me just make a comment or two about expanding Medicaid that you all might want to respond to later on, and then let me go with a series of questions.

I wanted to point out that if we expanded Medicaid—and I think I heard you, Mr. Bromberg, say if we were talking about expanding it for people who were truly under the poverty level—I would suggest that all of us engage in a very careful examination of how we define the poverty level. I think it is highly problematical, and if we truly want to make sure that people in need, including children, are covered, then I think Molly Orshansky, who first developed that in 1963, would be the first to talk about the need to reevaluate that.

My second point is we talked about combining Medicaid and Medicare, but the Medicaid part would be means-tested. I guess I would just sound a warning about what happens with means-tested programs. It is not as if middle-income and working people are not hurting—and not only not hurting, but I think quite angry about their costs.

So I always worry—albeit we have to start somewhere, and I understand the spirit of that—I always worry about going back to this principle of means-tested programs that divide one segment of the population against another.

The third point I want to make is in terms of the cost of this—and the chairman has been somebody who has raised this question over and over again—I just would remind everybody that I think to truly cover this, to expand Medicaid across the board, to Federalize it, to make sure we have decent minimal standards, I think would be a significant expenditure item and one that the budget agreement doesn't allow for unless we are willing to take out something else that might be very important. And somewhere along the line there is going to have to be some discussion about that budget agreement and the need to renegotiate it.

Now, after having said that, I am going to alternate my questions between really not-so-nice questions and nicer questions, and I'll start out with that disclaimer because I am going to ask a not-so-nice question, but I want you to think of me as a nice person.

In a recent report, the Congressional Budget Office noted that providers appear to have gained substantially from the rapid growth in health care expenditures. Providers are doing well. There is an analysis of hospital margins, there are the hospital physician salaries—I have all the statistics here, and I won't go through all of them—and I would leave nurses out.

Ms. REDMAN. Thank you.

Senator WELLSTONE. I would absolutely make nurses the exception. But this is the question. Given the fact that concomitant with this whole increase in expenditures is that the providers, with the exception of nurses and nurses' aides, have done quite well, can you really be objective in your analysis about cost control? I have to ask the question. I mean, some of the people you represent have done quite well.

Mr. BARRY. Senator, let me try and respond. I think we have tried very hard to be objective. I am not sure hospitals are doing quite as well as you think they are. Their financial condition continues to deteriorate. We are currently projected to lose about 8 or

9 percent this year on Medicare business alone and overall patient revenues, a substantial portion of hospitals are in the red even though other revenues which are not patient-related particularly do make up for some of that. We obviously do see a fair amount of hospitals that are in serious problems from a financial point of view, and that is of great concern, particularly in situations where those hospitals are genuinely needed. So there is some concern from that point of view.

Senator WELLSTONE. I know there is, and again, CBO talked about a 2.5 percent margin in the Seventies to a figure of 4.8 percent in 1990. That is certainly not an insignificant increase. I know you have problems, but that is substantial.

I just want to set the framework for this discussion for other questions I want to ask. You come in here, and you've got these questions, and you talk about cost control and that you don't want to have too much government rate-setting, and you are worried about that, and you've got good reasons. And I keep thinking as somebody who is new to this these people represent a lot of people who have done very well—so how objective can they be?

Mr. BROMBERG. Let me take a shot at that. Aside from agreeing with you that it is a not-so-nice question—because I think that question could be asked of anyone, Senator——

Senator WELLSTONE. Absolutely. I agree.

Mr. BROMBERG. You could ask some of the big businesses in this country that have given away everything at the bargaining table and now want a bailout are they objective. You could ask organized labor, which seems to have an awful lot of influence on these bills, if they are objective when they want to get the issue off the table so they can get wages. You could ask consumers, who every poll shows want more for less, whether they can possibly be objective.

Senator WELLSTONE. Right. But today I get to ask you.

Mr. BROMBERG. OK, then, I'll answer the question. I really believe that if I ever have to be a seriously ill patient in a hospital, I don't want to be in a hospital that is losing money and that has a negative margin, because I know what can happen there. I want to be in a hospital that has a 3, 4, or 5 percent margin. That's number one.

No. 2, those statistics you are quoting are not on patient revenues. The margin there is closer to one percent, which I think is dangerously low. Third, in the rate-setting States in this country, the margins are one percent versus your 4 percent. And we are not against controls. I must emphasize that. We are for almost every cost control bill in the Mitchell-Kennedy bill with the exception of two because we believe that those will lead to price controls, which will do exactly what you don't want. As the *New York Times* said, they will prop up fees and deter and inhibit the most promising trend we have, which is managed care.

So yes, I think we can be objective because we are advocates for patients, too. We'd like to see everyone insured. All we want is a fair payment. We are not ripping off. Even if your 4 or 5 margin is right, that's a lot less than a lot of other people in this country. And 99 percent—100 percent of it in the nonprofit case—and 90 percent of it in the for profit case of that margin gets put right back into the institution. It is not being taken home by someone.

So if we make 5 cents on every dollar, we also give 5 cents of charity care, and probably 20 cents of it goes to finance underfinanced programs like Medicare and Medicaid.

Senator WELLSTONE. OK. I'd like to go back to some of your concerns about the rate-setting in a moment, but first, Dr. Todd?

Dr. TODD. I think your question is a terribly important one, and I think the track record of the American Medical Association and the doctors of this country is really quite clear. It was back in 1977 that the American Medical Association convened a national commission on the cost of health care, and unfortunately the recommendations from that commission—which was not just doctors and providers—many of the recommendations from that commission were totally ignored which, if they had been implemented, perhaps would have ameliorated some of the problems we see now.

We have sponsored economic grand rounds all across the country, trying to get into hospitals to teach physicians how to practice cost-effective medicine. The fact that we are doing quite well statistically belies the physicians in the inner cities, with large numbers of uncompensated patients or Medicaid patients, some of whom have had to close their offices and move somewhere else, and yet they still are concerned. As we do our polls, one of the number one issues that physicians report to us that worries them is the cost of health care.

Yes, I think we can be very objective about it, very serious about it, and one of the things that really makes us unhappy is that because of the Federal Trade Commission and some of the Justice Department activities, we are unable to do some of the things we might like to do in controlling some of the excesses within our own profession.

Senator WELLSTONE. I appreciate it, and before Ms. Redman responds, I just wanted to mention to you all—I got a note saying there is not a lot of time, but I am going to ignore it and continue with a question for each of you, if I can—I appreciate your response. I actually wanted to see how you would respond so I could have some understanding.

Ms. REDMAN. Let me just respond that nurses see themselves as advocates for patients, and our concern about cost containment is that we see people daily in our practice who are terribly badly hurt, patients who are very badly hurt by the present system. We see that there are potential ways in which we can capture some of that money and reconfigure it. So therefore lies our concern.

Senator WELLSTONE. Let me ask some specific questions. I'll start with you, Barbara. You testified, and I thought it was very important, that the way the nursing profession defines the health care crisis is not just in terms of dollars and financing and cost control but also the need to restructure, to reorient, decentralize.

Ms. REDMAN. Correct.

Senator WELLSTONE. I wonder whether you could elaborate a little bit about what you envision in terms of the kind of restructuring that might take place as part of our reform.

Ms. REDMAN. My comments are laid out more fully in the written testimony, but let me say that we believe that the system should become much more consumer-friendly, serve consumers much better through availability of care, easily affordable, conven-

ient care in the community. When you hear stories of parents who are willing to waive their children's immunization because it is so difficult for them to get access to the health care system to get the immunization, for fully preventable diseases, then we are in a situation in which the health care system is not sufficiently available and affordable and convenient.

Senator WELLSTONE. Thank you.

Let me ask you, Mr. Bromberg, in your written testimony—and you covered some of this today as well—you have stated your objections to all-payer rate-setting. You said that one of the problems you saw was that you didn't think it really controlled costs effectively, and you have some figures there that actually surprise me a little bit.

You contend that rate-setting does not hold down expenditures. Let me just cite a recent study by Karen Davis and others that states the reverse. The authors—and I summarize—said, "Since research frequently yields conflicting, ambiguous results, it is refreshing that in the case of State rate-setting the empirical results are clear and consistent. Mandatory rate-setting programs do significantly slow the rate of increase in hospital costs."

Robert Reischauer, who is the director of CBO, recently testified that State all-payer rate-setting systems, "cut the rate of growth in hospital spending substantially, substantially below what would be expected without all-payer rate systems."

Now, in comparison to these analyses, based upon numerous studies, you cite only one contrary study in your testimony, and I have a couple of questions. One, I want to know whether that study has been published.

Mr. BROMBERG. Yes. I'd be glad to submit it for the record.

Senator WELLSTONE. I would like you to submit it for the record so that we could take a look at it. That would be very helpful. It sounds like it is important information for us to evaluate. As I remember, part of the way you questioned this issue of cost-effectiveness was that you looked at a couple of years and a couple of States that don't have it—Minnesota was one of them—and you said really they felt that they've done better in terms of holding down costs. And right away, having come from Minnesota, I started thinking does this study that has been published—and you say it has been published—control for such features as income level of the State, age of population, private insurance coverage.

It seemed to me you picked out a couple of States, not all the States, and a couple of years, and I wondered whether you controlled for these other variables. And it made me have questions about the whole thing. Do you know whether or not those valuables were controlled for?

Mr. BROMBERG. I'm pretty sure, but I'll have to check.

Senator WELLSTONE. Because it would make a huge difference.

Mr. BROMBERG. Well, not necessarily. I don't think those variables were controlled for, but I think this study was done to refute the claims of other people who didn't do the same variable adjustments that rate-setting had worked.

And both studies are consistent. The claim that the rate-setting States have slowed their growth of increase is correct and is not inconsistent with this study, which says that may be true, but their

rates of increase are still higher than the national average and significantly higher than those States with high managed care penetration.

Let me just give you an example—and it is an interesting example because it is interesting to look at occupancy, which is one of these villains we toss around a lot without thinking about it too much.

If the State of Utah were a country, there would probably be a trip there right now for a lot of members because it looks better than Canada and Germany. But when you compare Utah and Massachusetts—and I think lifestyle is the reason, clearly—I think also that if we had as many crack babies in Canada as we do here that the data might be a lot closer, too—but just let me give you the data. Utah has 50 percent hospital occupancy, and Massachusetts has 76 percent hospital occupancy. In the State of Utah it costs $574 per capita and $4,896 per admission to be in the hospital.

In the State of Massachusetts, it is $1,041 per capita and $7,956 per admission to be in the hospital. Now, that's for the year 1989, which is the last available data.

The State of Massachusetts has been going up at 9 percent a year, which is above the national average. But the rate-setting States, compared to States like California, which have high HMO penetration, have just not done as well; and we'll submit that for the record so you can see it. They have slowed the rate, it is correct. Karen Davis is correct. They have slowed the rate of increase, but we don't think they have slowed it as much as the national average or the competitive States.

Senator WELLSTONE. But you've just got a couple of States there that are more, as you say, managed care States. There are also States where we need to look at other variables like poverty, like age level—which have a lot to do with what would be spent, right?

Mr. BROMBERG. I agree. We just picked the 5 States that had the most HMO's and then the 5 most regulatory States and compared them. That's all we did. And I don't think Karen did it any differently. The proponents of rate-setting have not adjusted to those variables, either, is my point.

Senator WELLSTONE. And the social scientist in me says that you've got to control for those other variables.

Mr. BROMBERG. Yes.

Senator WELLSTONE. To move this along, I think I will submit in writing, if that's okay, Mr. Barry—did you have a comment?

Mr. BARRY. I'd like to make one brief comment on that, if I could, Senator.

Senator WELLSTONE. Please do, yes. I'm sorry.

Mr. BARRY. I think the issue isn't just cost containment or cost control in the sense that you are discussing it. I think most Americans want value for their dollars in health care, and I think a combination of high quality and reasonable cost is where we really need to be going. And that's the balance in the equation, and I think that is really important.

Sure, there are ways to squeeze down the system in any one situation, but I'm not sure we want those results. The proof of the pudding is that we have a system in which we spend more than any-

body else in this world on health care, and yet we have outcome indicators that aren't very good at all.

Senator WELLSTONE. That's right, and I would agree that cost cutting is not supposed to be in the direction of sacrificing quality of care—not at all—or to make the health care profession the kind of profession that men and women would not want to be a part of, or that people could not make a financial go of it. I have seen community hospitals close down.

The last quick question is for Dr. Todd. The recent JAMA editorial noted that the AMA surveys have found that the American people and American physicians consider cost as first concern, access as second. Then the editorial noted that a cost control program could include a number of different provisions. There are three that I'm interested in, and I just want to get your reaction—there were others listed, but the three that I'd like to focus on would be a maximum percentage of GNP for health capped by law; a second was overall national or State medical expense caps; and a third was expenditure targets.

What I'm interested in is whether or not you find yourself in agreement with these recommendations or not.

Dr. TODD. Not entirely, Senator. We do not believe that you can control health care expenditures and provide necessary and effective care in this technological age by just putting an arbitrary cap on it.

The AIDS epidemic by itself should indicate that it is going to be very difficult to predict what the future health care needs of this country are going to be, particularly as the population is aging and as new technology comes out.

Expenditure targets follow along much the same way, the Medicare volume performance standards. What is really needed is to look at how much health care we are giving in this country and find out how much of that health care is really necessary, effective, appropriate, and useful to the patients, how much of the health care that is given is given not because of ignorance or greed on the part of physicians, but because of professional liability, public expectations, licensing boards, Federal laws of the sort and, instead of using a blind sledgehammer to control expenditures, look at the individual components of those expenditures and find where you can reduce expenditures that are of no benefit to anyone. No physician wants to give unnecessary, inappropriate care. They need practice parameters to help them understand in some instances what is the best method of care. They need protection from professional liability to be able to say no, you don't need that procedure.

You know, the American public believes that for every condition there is a treatment, for every abnormality there is a procedure, and they want it done. And today's physician is caught between the devil and the deep blue sea of satisfying their patients and ending up in a professional liability or a licensing activity.

Our goal is data collection. I agree that managed care can have a great influence in how care is delivered, but it should be done by solid medical knowledge first and economics later.

Senator WELLSTONE. I thank you. I have to say, Dr. Todd, that I found it interesting and significant that JAMA would have even listed these items or recommendations as part of where we might

go. I think it tells us something about how important this whole question of getting some handle on the cost is and that everybody is going to be looking at what we need to do by way of cost control, and we need to do it in a responsible way, and I think each of you have talked about that.

Thank you very much, for Senator Kennedy and all of us. I really appreciate your being here.

Senator WELLSTONE. Let's move on to panel three. Our final panel consists of two major organizations representing the insurance industry. Carl Schramm is the president of Health Insurance Association of America, and Mary Nell Lehnhard is Washington vice president of the Blue Cross-Blue Shield Association.

Let's start off with you, Mr. Schramm. Thank you for being here.

STATEMENTS OF CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; AND MARY NELL LEHNHARD, WASHINGTON VICE PRESIDENT, BLUE CROSS-BLUE SHIELD ASSOCIATION

Mr. SCHRAMM. Thank you for having us, Senator Wellstone.

I appreciate having been invited, and I take it from the metier of the hearing so far that it might be much more productive for us to go quickly to questions.

Let me make a very brief abridgement of my statement. First of all I think, as Mr. Bromberg has indicated, there is—and I think it is important for the committee to witness—a revolution underway in the insurance world. Both in the house of Blue Cross and in the house of commercial insurance, where together, the Blue Cross plans and our member companies cover 180 million people, there are two significant intellectual, conceptual, pragmatic and management forces at work that must in fact be stimulated and encouraged by the actions of the Congress and not in fact stifled in their infancy.

The first is the revolution and thought about how our business operates as the small group market. As I hope you are familiar, our industry has led the conceptualization of changes that must take place in the operation of the small group marketplace.

The second, as Mr. Bromberg has alluded to today, is the revolution of managed care. Managed care is properly characterized as a revolutionary event in the sense that it realizes a total transformation of our companies and our cultures, from passively paying bills as an inactive third party administrator or financial intermediary into an aggressive, involved arbiter, challenger and disciplinarian of the delivery system as well as the financing system.

To adopt this bill, which we oppose, would essentially create, in the face of this emerging revolution, three tragic errors. The first revolves around the question of the "pay or play" provisions for employers that are the keystone of this legislation. In our view, these are fundamentally and fatally flawed. Let me elaborate.

Employers are given the option of providing their employees health coverage or contributing a percentage of payroll to have their employees covered under a public program—AmeriCare. In practice, every employer will examine his or her work force; they

will understand the data better than you or I, and they will make a judgment as to where to put the risk of covering their employees.

Who will enroll their employees in AmeriCare? I think it is absolutely clear—only those employers who expect their health care costs to exceed the AmeriCare premium. Those who expect high costs will elect AmeriCare. In other words, AmeriCare is guaranteed to lose money, as indeed the proposers of the legislation have articulated very clearly in the beginning.

This bill is also guaranteed to lose money on the nonemployed population which also has the ability to enroll in AmeriCare regardless of income. Open to all not covered by employer plans, regardless of income, AmeriCare premiums will be held down by political pressures, just as Medicare Part B premiums have been held down since their 1965 50 percent level.

So what will eventuate is that older, sicker and more expensive lives will sign up in AmeriCare. The younger and healthier will stay away. The private sector will suffer from a competitor whose premiums are set by political pressures, not costs or market forces. And the program deficits will grow, demanding either a dramatic infusion of funds or further takeover of the system.

We appreciate history on this point. It is as clear as anything in the history of health care financing. The government in this situation will cut coverage, force the providers to shift costs. And in fact, the problem we set out to cure will be caused to be greatly worsened.

We strongly recommend that Congress begin with a more modest expansion of public coverage to the poor and near poor, further proposals that HIAA has developed and advocated over the last 2 years.

While we are working hard to advance these programs, it is important that you appreciate that this bill throws yet another roadblock in the advance of the revolution in private insurance, and that is the concept of community rating provisions in this bill.

Community rating in itself will not save one dime, as you appreciate. It is essentially a redistribution mechanism. By averaging premiums that will increase costs for populations least able or willing to pay, particularly those with young workers, it will encourage those with lower costs to self-insure, perhaps unwisely, and increase the game-playing that already goes on between insurers and employers.

The net result, I would suggest, will be fewer, and the population that is at most risk of being uncovered being covered.

Understand, Mr. Chairman, we are well aware of the need for small market reform. There are few groups and few industries that could present the record of both the Blue Cross Association and HIAA in terms of demonstrated ability and interest in fundamental reform of our industry. Indeed, I would compare us against other witnesses here today and suggest that the proposals we have brought forward result in tighter shoes for this industry. We are not seeking more income. We in fact are seeking fundamental reform of the way in which we do business as regards the small group area.

We are encouraged to see the recognition given to cost containment in this bill to say something very positive, particularly the

attention given to managed care. Our companies have invested fortunes as part of this revolution. We have radically changed our culture and our companies. We have made promises to people that put us at grave risk. We are back in the risk business with managed care.

We particularly commend the provisions which prevent States from erecting barriers to effective managed care plans, and we strongly endorse the development of clinical guidelines, practice parameters, and the outcome measures.

But in closing, we have enormous problems with the concept of a Health Expenditure Board as a means of cost containment. We do not see any way that this board will do anything more than essentially conduct a discussion among all the parties and fail to result in cost savings for reasons that others have criticized before me.

In closing, let me just say one thing. We are in the midst of a revolution in thinking. I think that the great risk with this bill is that it throws the baby out with the bath water.

There are two fundamental issues at work here. One is the operation of the small group market, which essentially operates to keep people away from insurance at the moment. This industry is committed to changing that. But the second and more fundamental problem, the motor behind the problems in the small group market in the first place, is unbridled cost inflation in the provider marketplace. That does not operate because of greed or the interest of people in feathering their nests. I would suggest as an economist it operates because we have set in place certain structural issues; we have created markets that have momentum of their own.

Many of these momentums were put in place by the Congress as it in fact expanded the production of physicians and greatly stimulated the overcapitalization of our hospital system. There is nothing in this bill that goes to these structural problems, and until we change these structural problems, we will not see fundamental cost containment. A jawboning negotiating board won't get us there. Rate-setting won't get us there. What we need is a fundamental reform of insurance and health financing, a position this industry is committed to.

Thank you.

Senator WELLSTONE. Thank you, Mr. Schramm. I know you have a wealth of knowledge, and I appreciate your keeping your remarks short. I myself have to go to another meeting, so I do want to have an opportunity to at least ask a question of each of you and others will be asking questions, but thank you very much for being so succinct.

[The publication entitled "Health Care Financing for All Americans" is retained in the files of the committee.]

[The prepared statement of Mr. Schramm follows:]

PREPARED STATEMENT OF MR. SCHRAMM

I am Carl Schramm, President of the Health Insurance Association of America (HIAA). The HIAA is a trade association of private health insurance companies which provide health insurance to some 95 million Americans. Over the past few years we have given a great deal of thought to the health care access and cost problems. We have presented our views at numerous Congressional forums. It is a pleasure to share with you some of our thoughts on S. 1227.

The breadth and detail of this legislation alone point up the complexity of the access and cost issues. History has demonstrated that simplistic solutions are often poor solutions in the health care arena. In my view, this legislation represents one of the first serious efforts to acknowledge the complexities of our system, and in doing so, to view the health care access and cost issues systemically. For this I strongly commend you. Many of the concepts contained in this legislation are very good ones and consistent with our thoughts. I will outline these. I will also outline areas where HIAA has significant reservations and disagreements with the legislation which force us to oppose the bill.

At the most general level, S. 1227 recognizes the importance of pursuing a joint public/private effort. Today, the vast majority of Americans have some form of health insurance coverage. More than 180 million Americans are covered privately. Moreover, our pluralistic system provides an important degree of choice and serves as a major driving force for innovation in health care financing and delivery (through, for example, managed care). The intent of S. 1227 is clearly to enhance and expand both the public and private financing systems. We think that such a strategy is consistent with both the will of this country and current fiscal realities.

It is clear that both public and private financing systems in this country are in need of significant change. S. 1227 recognizes that our current system fails to adequately meet the needs of low income populations. HIAA supports expansion of public coverage and financial assistance to the poor and near poor populations. We also support increasing provider reimbursement levels under public plans to adequate levels. However, we do believe that the expansiveness of the AmeriCare program, as well as its structure, would present major operational problems.

The funding base for the AmeriCare program is similar to that of our current Medicaid program. Historically, one of the principal problems with the Medicaid program has been its inadequate fiscal base. Medicaid has been chronically underfunded since its inception, and today covers only 40 percent of the poor and reimburses providers at inordinately low levels. AmeriCare would also obtain its funding through a joint federal/state match but would vastly expand the covered population. Simply stated, government, and especially state government, is not in a position (and has not shown a willingness) to provide adequate funds to support an expansive public insurance program.

The problems associated with the fiscal base of AmeriCare will be exacerbated by the method in which employees may become eligible for AmeriCare coverage. Under S. 1227, employers would be given the option of either providing their employees coverage or contributing towards coverage of their employees under the AmeriCare program. One of the major public policy objectives of such a "pay or play" option is to give financial relief to employers who find it difficult (if not impossible) to bear the full costs of providing health benefits. HIAA strongly supports financial subsidies that are efficiently targeted to those most in need. However, the pay or play system envisioned in S. 1227 will result in other counterproductive outcomes.

Because Americare plan eligibility is determined based upon a percentage of employer wages, only employers who expect their health care costs to exceed the required wage contribution will enroll their employees in Americare. In other words, Americare is guaranteed to lose money on the employer-based population that opts into it. Americare is also guaranteed to lose money for the low income, nonemployer-based population for which premiums and copayments are partially, if not fully, subsidized by the program.

Confronted with large and mounting losses, Americare will be faced with the option of obtaining either a major new infusion of public funds or infusion of financing from populations originally intended to be outside the purview of the Americare program. That is, there will be strong incentives for Americare to obtain enrollment from a broader (lower cost) cross section of the population (rather than just those whose costs exceed a given percentage of wages) and/or to selectively lower provider reimbursement rates under Americare to offset mounting losses. The latter option will result in an unsustainable and unfair cost-shift from Americare to non-Americare enrollees.[1] Either scenario will result in unfair, direct and growing competition with private plans. In some local, higher cost areas, the program may lead to major or complete substitution of public for private coverage. The growing dichotomy between public and private markets will also strongly penalize providers that become disproportionately reliant on public coverage revenues and potentially threaten their solvency.

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[1] While the bill intends to rectify the cost shifting problem by allowing for the establishment of uniform rates, experience in this country suggests that states tend to waive the all payer requirements for Medicaid. Cost pressures make this scenario also likely under S. 1227.

It's important to note that the dynamics described here will not be the result of any inherent efficiency of public coverage, but rather will be the outcome of the public program's artificial and unsustainable advantages over alternative private plans.

Our recommendation would be to begin with a more modest expansion of public coverage to the poor and near poor populations. For poor and near poor workers, public plans should begin by experimenting with workers who would normally be eligible for both public and employer coverage. We call this population the Medicaid buy-out population.

This course would avoid the financial woes associated with the implementation of a large public program. At the same time, additional thought and research needs to be devoted to developing a better and more sustainable interface between the public and private markets.

HIAA supports S. 1227's provision of additional financial relief to small and previously uninsured employers by extending a 100 percent deduction to the self-employed and special tax credits to low wage employers. We also support the concept of providing direct subsidies to assist low-income workers in paying their share of premiums and cost-sharing.

As you may know, HIAA has been a leader in the insurance reform movement and has developed a broad range of recommendations in this area. We support the objectives of guaranteeing availability, continuity of coverage and limiting excessive rating practices. We also support the concept of making lower cost benefit plans available to purchasers. However, we do have disagreements with many of the specifics in S. 1227.

For example, the legislation envisions the establishment of community rating in the small employer marketplace. A movement towards community rating would have negative side effects. A community rated system would increase costs for populations least able and willing to pay (especially young workers), subsidize populations with greater incomes who are already more likely to be insured (i.e., old workers), and substantially increase the risk of insurer insolvency. Community rating also compromises local accountability for health care costs since the actions of an employer have little if any effect on the costs that it bears.

On average, the currently uninsured population is younger than the insured population and often places less value on insurance. This reflects both their much lower average health cost experience as well as their lower earnings. While one in four 18–24 year old full-time, full-year principal earners have family incomes below twice the poverty level, only one in ten of such 55 to 64 year old workers have family incomes beneath this income level.[2]

Furthermore, low-wage workers tend to be concentrated in firms that are financially more fragile and are least likely to offer coverage. Younger, currently uninsured persons and their employers will be even less able to purchase coverage if premiums are raised to a community rate.

In addition, community rating creates incentives for employers who are currently insured to self-insure, and we see nothing in the legislation that would offset or prevent this incentive. Low risk employers (e.g., those with younger populations) will often find it advantageous to pay rates reflecting their lower expected health costs rather than to subsidize heavily higher risk (e.g.-older) populations employed by other firms. While self-insurance is a viable option for larger employers, it is not an acceptable option for small employers (which are too small to adequately spread the costs of a high risk individual). Nevertheless, our survey data suggests that the number of medium and small employers that are self-insuring (almost certainly unwisely), and who are operating outside any formal regulatory structure is increasing. The result of community rating could well be spiraling health care costs for insured populations and a growing number of employees without adequate protection as more and more lower risk populations leave insurance pool arrangements.

Community rating can also threaten the solvency of individual insurers. Individual carriers or competitive health plans need some latitude to adjust rates if they are to maintain financial solvency. For a variety of reasons, any given carrier may experience the enrollment of insureds who are, on average, older and sicker than marketwide norms. If a carrier who has an expensive enrollee population is required to charge one community rate for all clients, it would be put in an untenable position. In order to stay price competitive, the carrier could charge a premium that is less than its average cost experience, but it would immediately sustain large losses. If it charged premiums to cover current costs, it would lose its lower risk

[2] Tabulations from March 1990 Current Population Survey

clients and be unable to attract new lower risk clients because its rates would be too high. As the carrier's per enrollee costs spiraled upward, and its enrollment of average risk persons declined, it would incur larger and larger losses. With some latitude to adjust rates, such a carrier can set a premium price that can attract new lower risk groups and thus improve its ability to spread the costs of higher risk groups over time.

Community rates that do not vary by geographic area compromise local accountability for costs. Such schemes would force lower cost, more efficient and often lower-income localities to subsidize higher cost, less efficient localities that often have higher per capita incomes. For example, rural areas could be forced to subsidize more costly urban areas. Market pressures to control costs would be muted as employers who use inefficient provider networks are shielded from the true costs of such inefficient care.

In expressing our opposition to community rating I do not want to suggest that substantial rating reform is not necessary. In fact, today there are rating practices which are simply unacceptable from a consumer, public policy, and industry standpoint. HIAA and others have developed rating reforms which would substantially curtail excessive rating practices without going as far as a community rating scheme which would bring with it the range of negative consequences I described earlier. (See the attached.)

We are encouraged to see the bill's emphasis on cost containment, and particularly to the key role assigned to managed care plans. HIAA has consistently taken the position that solutions to the access problem have to be coupled with, if not preceded by, effective steps to limit the escalation of health care costs. And we believe that any effective cost containment approach must promote development of managed care plans.

In particular we commend the provisions which prohibit states from hindering managed care plans' capacity to select providers to make up networks, to limit the number of participating providers, to pay providers in innovative ways and at alternative rates, and to incorporate incentives for consumers to use participating providers. Likewise, we heartily endorse the provisions which prohibit states from imposing barriers to effective utilization review, since this form of medical management is critical to implementation of cost-effective managed care plans.

HIAA is also a strong supporter of technology assessment and the development of clinical guidelines, practice parameters, and outcomes measures. We are happy to see that this bill gives increased support to efforts to improve the state of medical knowledge in these important areas. As an association we are already taking steps to implement one of the provisions of the bill in this area, specifically a public-private partnership to enhance the speed and efficiency of technology assessment activities.

HIAA concurs with the sponsors of this bill that malpractice-related costs are an element of cost escalation that deserves attention. We have no objections to the provisions of the bill which would provide grants for innovative efforts to reduce the administrative costs and burdens of malpractice disputes, and we also support the proposal to have the Institute of Medicine study the elements of the problem and make recommendations for change. In addition it is important to minimize the occurrence of malpractice by changing practices that cause malpractice, since this approach improves patient welfare as well as reduces costs. We are also on record in support of specific changes in legal doctrines that govern malpractice litigation.

In principle we support several of the directions for reducing administrative costs. We agree that movement toward uniform billing and claims forms and electronic submission of bills and claims is desirable. In fact, HIAA and a number of its member companies have for several years been actively pursuing these ends with other payers, including Blue Cross and Blue Shield plans and the federal government. Substantial progress has already been made. We cannot, however, support the proposal for requiring all small-share insurers (as defined by the Secretary) to submit bills through a state consortium. The uniform electronic billing approach we are pursuing would obviate any need for such an approach.

The portions of the cost containment sections in which we have the most serious reservations are those concerning the functions of the Health Expenditure Board (and potentially state consortia). While our association has no specific policy on the proposal to have the Board set and enforce expenditure targets, the idea raises a number of troubling issues. An overriding and critical question is whether or not an independent board, such as the one envisioned in the legislation is an appropriate and effective model for making decisions on cost, quality and access.

One specific issue of great concern is the Board's authority to set provider rates through a negotiation process. We have strong reservations about any system that

would establish uniform rates for all payers. The ability to negotiate both the rate and form of payment with providers is a key element of managed care plans. The freedom to negotiate a mutually acceptable rate is necessary because innovative payment arrangements may be critical to providing incentives for providers to change behavior in desired ways. Although the bill precludes states from limiting rate negotiation arrangements for managed care plans, it apparently does not exempt such plans from the rates that are approved by the Expenditure Board. It is not at all clear how the imposition of uniform provider payment rates could be reconciled with the critical need that managed care plans have for freedom to negotiate with providers.

Moreover, we question whether such a process, whether done at the national level under the Expenditure Board or at the state level by the Consortia, can be successful in the United States where the climate is unique, particularly with respect to the adversarial nature of relations between purchasers and providers. Can providers and payers really be expected to reach an agreement, or will the more common case be a stalemate? Providers, in particular, have an incentive to refuse to accept rates that substantially constrain their incomes, since in the instance of such an impasse, the Board makes an advisory rate decision which is not binding on the parties with the result that everything is left largely as it is now. Such collaborative, voluntary efforts have in the past not met with much success in this country.

Before closing I believe that it is important to recognize that we have yet to find the "right" answer to our cost and access problems. I am a firm believer that answers require time and experimentation. As we travel down the road of health care reform, we will undoubtedly find that there is no single right answer. Some of the "answers" that we propound today may be found wanting and in need of revision. For these reasons, the HIAA believes that access 'and cost proposals should retain significant flexibility. The states should be the principal locus of regulatory and oversight activity. We are opposed to giving the Secretary of HHS the range of authority granted under this legislation. Moreover, we are concerned with the cumbersome and duplicative nature of the regulatory/oversight apparatus. We are particularly concerned with its potential negative impact on the development and evolution of managed care systems.

I will close by saying that we very much appreciate the opportunity to testify on S. 1227. We too have a series of recommendations on access and cost which I would like to submit for the record. Together I believe we can forge meaningful solutions.

Senator WELLSTONE. Ms. Lehnhard.

Ms. LEHNHARD. First of all, I want to commend Senators Kennedy and Mitchell and the other cosponsors of the bill for their leadership on this issue. We think that introduction of HealthAmerica signals a new level of commitment to the attempt to resolve the current problems in the health care system.

The Blue Cross and Blue Shield Association supports the underlying objective of the bill which is to assure that every American has health insurance coverage and put in place strategies to make the cost of care more affordable.

We share the belief of the sponsors of the bill that building on a pluralistic system is the best way to achieve these objectives.

I'd like to very briefly make comment on three aspects of the legislation—the cost containment strategies, insurance reforms, and the mechanism to assure that employees whose employers don't offer coverage have some type of health benefits in place.

First, we strongly support many of the cost containment strategies in the legislation. In particular, we are very encouraged by the promotion of managed care, and we think these provisions could in fact be strengthened by creating incentives for employers to use carriers that have in place effective managed care programs.

We also support the waiver of State-mandated benefit laws, and our testimony highlights many of the other proposed strategies that we agree are needed.

Our primary concern is with respect to the bill's emphasis on all-payer strategy, something you have heard today. Like others here today, we don't think that a highly regulatory payment scheme will be effective in addressing the two basic problems in this country—not so much price, but excess capacity and excessive use of services. We believe that all-payer systems in fact lock in place excess capacity and prevent insurers from negotiating with providers in the best interests of subscribers.

We in fact encourage that as an alternative you strengthen the managed care incentives in the legislation and allow insurers to send their patients to the most efficient, highest-quality providers.

We are in agreement that the insurance market is in need of reform, and we support immediate steps to assure that competition is based on the ability to control cost, not the ability to select the best risks in the market.

We support the general framework of the insurance reforms in HealthAmerica, and we would like to work with you on the right balance between broad Federal guidelines and State flexibility.

We are especially pleased that the bill clearly includes all entities in the insurance market under the regulation of the proposal, including multi-employer welfare associations.

Our major concern is that the provisions to limit how much carriers can adjust their premiums for high-risk groups, the rating reforms which Mr. Schramm mentioned, will result in immediate disruption in the market. The lower premiums for high risk groups will result in significant increases in premiums for the lower risk groups, and the majority of the market is made up of these lower risk groups.

We believe that this redistribution of subsidies in the small group market needs to be approached much more incrementally to avoid the healthier risk groups incurring significant cost increases.

Finally, we would like to work with the bill's cosponsors to find an alternative to what we believe is the most troubling aspect of the bill—the alternative of a public pool for employers who don't choose to contribute to coverage.

Our fundamental concern with the "pay or play" structure is the incentives for overtime, the public pool to evolve into the major source of coverage for employees—and I won't go into that; you have heard much of that from Carl Schramm.

While we recognize, however, that there are problems with the public pool, we feel we need to find a way to work to find coverage for those employees whose employers don't offer a contribution to that coverage, and we would like to work with the sponsors of that bill on an alternative to the public pool.

In summary, we strongly support the objectives of the bill. Our concerns are the broad public pool, the emphasis on all-payer systems, and the proposed rating reforms, community ratings. But we would like to work with you on alternatives to strategies to deal with the underlying problems.

Thank you.

[The prepared statement of Ms. Lehnhard follows:]

Prepared Statement of Mr. Lehnhard

Mr. Chairman and Members of the Committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the plans provide health benefit protection for more than 70 million Americans.

Since their inception in the 1930's, Blue Cross and Blue Shield Plans have been committed to developing and improving the nation's pluralistic health financing and delivery system. To that end, we work in partnership with consumers, employers, unions, health care providers and government. That commitment continues today as we address the complex issue of providing access to care for the nation's uninsured.

We welcome the opportunity to address the Committee on this important matter. In my testimony today, I will:

—Discuss how we believe we can build on the employer-based system to assure coverage for all Americans; and
—Provide our comments on S. 1227, the "Health America" bill.

The Blue Cross and Blue Shield System is committed to the challenge of finding ways to assure coverage for all Americans. We continue to believe strongly that the pluralistic system is the best way to meet the health care needs of all Americans. This is a framework that helps assure Americans a degree of independence and choice, room for creative ideas, and the medical advances and quality care they have come to expect. We have identified three broad steps that we must take to make our pluralistic approach more effective.

Step One: Make Coverage Available for All Americans

The first step is to assure coverage for all Americans. Given that over 80 percent of the approximately 37 million uninsured Americans are either workers or dependents of workers, we believe the best way to provide high quality health care that meets the needs of this population is through the employer-based system.

Currently, we are considering how to expand the number of people covered under the employer-based system and make other necessary improvements. The challenge is to find the appropriate mix of incentives and direct subsidies to encourage employer contributions. Before significantly more employers can be encouraged to purchase coverage, we recognize that the very real problem of affordability needs to be addressed. We also recognize continuity of coverage needs to be addressed by developing ways to assure that lapses in coverage are avoided as people move from one health program—whether public or private—to another. These are "portability" issues.

The Blue Cross and Blue Shield Association also is considering how to address the coverage needs of non-working individuals. We believe a combination of public and private plans is appropriate. A key focus of our deliberations is how to maximize the use of tax subsidies to minimize reliance on public coverage and to bring private coverage within the reach of more lower-income individuals.

Step Two: Make Coverage Affordable

The second step toward meeting our overall objectives is to assure that coverage is affordable. To address this issue, it is necessary to consider both the absolute level of health care costs and the role that benefit design and subsidies play in the affordability equation.

Health care costs are comprised of two factors: (1) the price per unit of services; and (2) the number of services used. Price is affected by such factors as capital, technology, costs associated with medical malpractice and, to some extent, practice patterns of providers.

In general, we have been fairly successful in controlling price, largely through provider contracting. Blue Cross and Blue Shield Plans have a long history of controlling unit prices through contract arrangements with hospitals that limit subscribers' liability while assuring an appropriate amount is paid for covered services. Plans also have contract arrangements with physicians that limit payments to amounts that are reasonable and protect subscribers from "balance billing" by providers.

However, our ability to control utilization has been affected significantly by uncontrollable factors such as new technologies, demographic changes, consumer demand for health care services as well as practice patterns of providers.

To assure more appropriate use of services, Blue Cross and Blue Shield Plans have implemented and achieved some success with a broad array of cost containment programs. They include: extensive use of preauthorization of health services;

concurrent utilization review; post-payment review; review of new technologies; discharge planning; and individual case management.

We have sharpened our strategies for negotiating reimbursement rates and increasingly are selecting providers in our managed care networks to achieve cost-effectiveness and quality care.

Clearly, there are continual changes in the delivery of health care services, and they require constant adjustments and improvements that the private sector is in an ideal position to undertake.

In addition to addressing these larger cost issues, we also must consider how to make coverage more affordable to employers, especially small employers, and employees. This means making the best use of tax subsidies and assuring an efficient insurance market. In particular, we are examining how tax subsidies could be used to reduce reliance on public programs, to increase private coverage for those currently uninsured, and mainstream lower-income individuals into private coverage.

A final consideration in improving affordability is the design of a benefit package. The Blue Cross and Blue Shield Association supports access to a basic set of benefits for all Americans, but we believe that the design of a benefit package balance the competing needs of adequate protection, affordability and incentives for appropriate use of services.

We believe that through these initiatives, there is much the private insurance industry can do to help address the overall cost issue. However, we can not affect major changes in health care costs and assure affordability of coverage on our own. To achieve this goal—and the corresponding objective of increasing access—all of the parties involved must participate in the solution.

Step Three: Assure a Well Functioning and Competitive Insurance Market

The third and final step we support is assuring a well functioning and competitive insurance market. This step is essential to assure access through a pluralistic system.

One action to improve the efficiency of the market is to eliminate the current imbalances between self-funded and insured benefit plans. Because ERISA protects self-funded employers from state regulation, these employers are not required to provide state mandated benefits—nor do they pay state premium taxes or share in the costs of state-run, high-risk pools for individuals. Thus, these costs are shifted on to insured employers, who tend to be small and medium-sized companies that can ill afford these additional costs.

We also recognize that market reform is necessary to replace competition based on ability to select risks with competition based on administrative efficiency, service and ability to control costs. The specific small group market reforms the Blue Cross and Blue Shield System supports include:

—Assuring that small employers have access to private insurance, regardless of health status, occupation or geographic location;
—Assuring that states have a range of options to choose from in providing for the availability of private insurance to small employers;
—Assuring that small group coverage is provided at fairly established rates;
—Assuring that no small employer is dropped from coverage because of poor claims experience;
—Assuring the adequate effective enforcement of all carrier requirements;
—Assuring the equitable sharing among insurers of both high-risk small employers and the losses associated with covering these high risks; and
—Assuring the availability of lower-cost products.

With respect to making sure that small employers have access to private insurance, Blue Cross and Blue Shield Association believes that states should have the flexibility to develop approaches to address the unique problems in their small group markets. The nature of the access problem varies from state to state, as do insurer practices. States should be able to choose or adapt approaches that meet their particular needs.

As for access to individual coverage, our current position is that states where Blue Cross and Blue Shield Plans do not provide coverage on an open enrollment basis to individuals should establish high-risk pools to provide access to coverage for uninsurable individuals. However, we recognize that changes may be needed in the individual market.

It is important to understand, however, that reforming the individual market will be much more difficult than reforming the small group market. Of all the health insurance markets, the individual market has the most severe problem of adverse selection.

Before leaving this discussion of the insurance industry, I would like to comment on insurers' administrative costs. Many people point to the administrative costs of insurers as a target for cost-savings and question the "value" of a private health insurance system. Blue Cross and Blue Shield Plans are proud of their record of providing an average of 90 cents in benefits for every $1 in health benefits premiums.

Comments on S. 1227: The Health America Bill

I would like to turn now to our comments on S. 1227, the Health America bill. This bill would assure universal coverage through a "pay or play" approach. Employers would be required to provide a specific level of coverage directly to their employees or would pay a tax to finance their coverage through state-run insurance pools. These public pools also would provide coverage for low-income individuals, replacing Medicaid for acute care services. In addition, federal requirements—including guaranteed issue and community rating—would be established for small group insurance insurers. Other provisions include cost containment and quality improvement initiatives.

We commend you, Mr. Chairman, and the other co-sponsors of the Health America legislation for your hard work in crafting this proposal. We are strongly supportive of the basic intent of the legislation—to build on the current pluralistic system of financing health benefits. While we support many of the approaches set forth in the legislation to addressing current problems, we also will highlight some areas where we would like to work with you on alternative approaches.

Our comments reflect only an initial analysis of the bill. After a more thorough examination, we will be able to provide more complete comments. The three areas our testimony will address are the bill's provisions for: (1) universal coverage; (2) affordability; and (3) insurance reform.

Universal Coverage. We support the stated intention of the legislation to encourage employers to provide health benefits to their employees through the private insurance system. A key issue for us, and others who support continuation of the employer-based system, is whether this design, in fact, encourages employers to contribute to private coverage and employees to accept this coverage.

The major reason some employers do not currently provide coverage is cost. The bill addresses some of the specific affordability problems faced by employers—both those who currently offer coverage and those who do not, especially small employers. The availability of tax credits and provisions for new small employers and marginally profitable small employers all should modify the financial impact of the bill's requirements. In addition, the bill has a major emphasis on strategies to control overall health care costs.

Our fundamental concern with the "play or pay" structure—the requirement that employers either provide a specified level of benefits directly or pay a payroll tax and send their employees to a public pool for coverage—is its inherent incentives for employers to increasingly abandon their role in providing benefits directly, and send their employees and their families to the public pool for coverage.

We recognize that the intent may be to set the "pay" part of the program at a level that encourages employers to provide coverage directly, through private insurance, to their employees. However, there will be enormous pressure to set the tax on employers who do not provide benefits at a very low level—a level below the actual cost of coverage. And, even if the tax were set at a level sufficient to cover those costs at the outset of the program, it would be difficult to adjust the tax sufficiently each year to maintain an incentive for employers to continue providing coverage directly, as health care costs continue to increase at a faster rate than the wage base.

In other words, while the bill is designed to provide employees continued access to private coverage, we believe that over time, the increasing incentives to use the public pool as an alternative to private coverage would result in a massive, federal program as the major source of coverage for employees. Further, we do not believe the pool will be responsive to the needs of employees. The link between employers and employees in the current system provides for a degree of accountability and attention to individual employee needs that could not be sustained under a public program, for example through the design of employees' benefit packages.

While we have serious problems with the public pool, we recognize that employees whose employers do not offer coverage need a source of coverage that is available regardless of medical condition, has premiums established on an equitable basis, and is affordable. We currently are analyzing private sector options to the large public pool.

Affordability. Notwithstanding the need for subsidies for certain employees and employers, it is also fundamental to assure that benefits are affordable by establishing initiatives to control the cost of health care services. We commend the bill's sponsors for their commitment to a comprehensive cost containment strategy. We strongly support many of the strategies proposed, in particular the promotion of managed care. We believe that the emphasis on managed care could be strengthened by creating strong incentives for insurers to provide effective managed care programs and incentives for employers to use managed care insurers.

We also strongly support the pre-emption of state mandated benefits provided by the legislation. In the absence of these mandates, insurers could reduce the cost of coverage, especially in the small group market. However, we are concerned that the comprehensive nature of the benefits required under the bill would impair insurers' ability to develop lower-cost benefit packages.

In addition, we support the bill's recommendations regarding investment in outcomes research and practice guidelines and a shared public and private sector responsibility for assessment of new technologies.

Our major concern with respect to the bill's cost containment strategies stems from the heavy emphasis on all-payer programs. This emphasis is reflected in the Federal Health Expenditure Board provisions which encourages negotiations between providers and purchasers to reach agreement on universal payment rates. There is a similar emphasis on all-payer strategies in the requirement that insurers make Medicare payment rates available to small employers. We also are concerned that all small insurers in a state would be required to use uniform payment rates.

We believe that current problems such as excess capacity and inefficiencies would become locked into place if payers were prevented from negotiating in the economic interest of consumers. Governmentally established payment rates would inhibit insurers' ability to make the most efficient contract and payment arrangements with providers.

All-payer systems also must rely on "rough justice" and are not capable of addressing unique needs at the community and institutional specific level. The inability to address these special needs could leave some communities without adequate access to services.

We believe that as an alternative to such regulatory payment schemes, there should be stronger incentives for employers to use entities to finance and deliver services that have a proven "track record" of managing the unit price, utilization and quality of services—managed care insurers. We believe that the most effective arrangements are those in which the parties at economic interest are free to negotiate and come to agreement on the price of services.

Insurance Reform. The third major area I would like to address is the insurance reform provisions. The Blue Cross and Blue Shield System historically has supported state regulation of insurance. However, in the context of major health access legislation, we recognize that Congress may want to assure that some basic insurance reforms are in place in all the states, so there can be effective implementation of the overall reforms.

We support the maximum role possible for states in the regulation of insurance enrollment, rating, and pricing practices. Health America, while prescribing some federal carrier requirements, does retain a significant role for states to implement these requirements and regulate compliance. We believe the proposed division of regulatory responsibilities offers an appropriate opening to a dialogue on the proper balance between federal and state authority in this area.

We are concerned about the "look behind" authority granted HHS. Under this provision, in addition to direct state regulation, HHS could review individual health plans to assure compliance. We believe this would result in burdensome and costly dual regulation for insurers, and we recommend that this provision be dropped.

With respect to the specific insurance reform provisions, we strongly support the legislation's inclusion of all financing entities, including self-funded, Multiple-Employer Welfare Arrangements (MEWA's). Even application of these standards across all financing entities is critical to the effective implementation of these reforms. We also support the bill's requirements regarding carrier registration and guaranteed renewability.

Community Rating. We have major concerns about the strict community rating requirements. After a transition period, the bill would permit rate adjustments only for age and these adjustments would be limited to 10 percent within a block of business.

Our primary concern with these strict limits is that healthy small groups—and most small employer groups are healthy—would experience sizable rate increases under this proposal, further exacerbating affordability problems. On average, only

four percent of enrollees generate 50 percent of claims, while 20 percent of enrollees generate 80 percent of claims. In simple terms, this means that as rates for the 20 percent high-risk enrollees were modified, rates for the 80 percent lower-risk enrollees would increase.

We also are concerned about the competitive disadvantages for insurers that traditionally have had, or continue to have, more liberal enrollment practices. Their enrollment of higher-risk, higher-cost individuals would result in a community rate that would not be competitive in the market. Perversely, this requirement would reward insurers that have been very selective in the risks they have previously accepted.

For these reasons, we support the rating reforms adopted by the NAIC last December. These reforms address abuses in current rating practices, which can result in very high rates for some small groups. The reforms would allow the use of demographic rating adjustments, but they would limit the extent to which a group's own experience or health status could be used in setting its rates. In this way, insurers' abilities to set rates that more closely reflect a group's experience would be balanced with the need to subsidize the rates for higher-risk groups.

The reforms also would take the important step of limiting the amount of annual premium increases due to a group's own experience or health status. As a result of these reforms, rates for higher-risk groups would be moderated over time, although rates for lower-risk groups would increase.

Quite simply, we do not know enough at this time about the consequences of rate compression to be able to support any provision that goes beyond the NAIC rating limits—even with the phase-in provided in the bill. We, therefore, recommend inclusion of the NAIC rating requirements in the small employer carrier provisions.

Alternatives to Guaranteed Issue. We also believe that approaches for assuring access to coverage for small employers other than guaranteed issue—a requirement that all insurers accept all groups—should be allowed. We recognize your strong interest in the guaranteed issue approach, and we agree that this approach may be appropriate in some states. Where such approaches are appropriate, we are particularly pleased that the bill would leave decisions about reinsurance mechanisms—which generally would include a guaranteed issue requirement—to the states. We also support providing states with reinsurance design options—including retrospective reinsurance.

We feel that the models developed by the National Association of Insurance Commissioners (NAIC) offer states necessary guidance in developing these programs. However, we urge that Congress require states to adopt these models verbatim. Given the untested nature and extreme complexity of these mechanisms, states will need flexibility to modify these programs both at the time of implementation and as they gain more experience.

However, we believe that other mechanisms for assuring access also should be permitted. Reinsurance mechanisms are extremely complex, requiring a strong commitment by the state to implement and administer them. More importantly, because reinsurance would allow insurers to shift most of the cost of high-risk enrollees to an outside entity, insurers would have a very limited incentive to manage reinsured claims, because they would not be finally responsible for those claims.

If federal legislation were enacted, we would recommend that the Secretary of Health and Human Services have the authority to approve the use of mechanisms other than guaranteed issue, as long as those mechanisms assured that all small employers had access to private insurance. These other mechanisms could include, for example, an allocation program, whereby groups that have been determined to be uninsurable could select coverage under a program that would distribute such groups equitably among all small group insurers in a state. A major advantage of this approach is that insurers have an incentive to manage the claims of these groups. This approach removes the need for a reinsurance mechanism.

Benefits Package. Another area of concern is the required benefit package. Rather than allowing insurers to offer only packages that include the minimum benefits outlined in the bill, we suggest requiring insurers to offer standard packages in addition to their other products. These would be the benefit packages that would be available on a guaranteed issue basis. One package could be a comprehensive set of benefits, such as those outlined in the bill. The other might be a "standard," scaled down, package. Employers would have to offer their employees at least the standard package, but also could offer other, richer benefits. This modification would assure that all employers had a lower-cost, more affordable alternative available, but also would be able to tailor benefits to meet the specific needs of some small employer groups.

Small Group Size: We also would like to comment on the application of the insurance reforms to groups up to size 100. Because problems of availability and rating of insurance tend to be focused in the under-25 life market, we recommend limiting carrier requirements to this market.

We understand the interest in extending these reforms up to groups size 100, particularly because of the additional cross-subsidies in rates this would provide to smaller employers. However, as a result, the rates for medium-sized groups would have to increase.

In addition to concerns about applying rating rules to groups up to size 100, we also want to raise the issue of including these larger groups in any reinsurance programs. If the requirements are to apply to all coverage in this size range, we strongly urge that insurers not be permitted to reinsure groups over size 25. Insurers already accept the risk of insuring groups over size 25; their inclusion in a reinsurance mechanism would increase significantly the size of the reinsurance pool, and thus increase the subsidy necessary to support its losses.

CONCLUSION

In conclusion, the Blue Cross and Blue Shield Association strongly supports the objective of S. 1227, to assure access to affordable health coverage to every American. Our specific concerns with the bill are its reliance on a public insurance pools, its emphasis of all-payer programs, and the need for insurance reform provisions.

Despite these concerns, we believe the bill provides a good vehicle for moving forward the debate on universal access, and we look forward to working with you as this debate unfolds.

Senator WELLSTONE. Thank you.

Let me ask one brief question of the two of you. First, by way of prefacing the question, let me say that both of you put quite a bit of emphasis on managed care, and for myself I want to learn more about it. There was a CBO report that came out not that long ago which was quite skeptical about some of the savings that could come from managed care. It was fairly critical. You may have seen it. I think there is a real place for it. I come from a State where certainly that has been part of the way in which we finance and deliver and health care. So I want to be clear that I think there is a place for it, although I would like to take a very careful look at it.

Let me ask two quick questions, and I will be succinct and read them in part. If it is okay, I will start with you, Ms. Lehnhard. One of your concerns about S. 1227 is the all-payer program as it fits into cost containment. This has to do with the Health Expenditure Board. Your point is that the most effective arrangements are those in which the parties at economic interest are free to negotiate about prices; correct? You'd like to see it that way.

Ms. LEHNHARD. That's right.

Senator WELLSTONE. I was going to ask a question, but I'll do it another way. I think that is what we already have, and I think it has failed. I mean, isn't that what we have right now?

Ms. LEHNHARD. I think what you are beginning to see in the market, and Carl alluded to this, is nothing short of a revolution. I think for the first time we are able to identify those providers, particularly physicians—that's where the bulk of the problem is right now, with outpatient utilization—those physicians who are very efficient in the way they deliver services and are high quality, and instead of trying to manage the entire physician population into providing care efficiently, we are able to select those physicians that already are efficient and channel our subscribers, our patients, to those physicians through economic incentives.

What we are finding is that after identifying those physicians—and we may in fact want to pay them more than we are paying other physicians, and that's where an all-payer system can hamper some of our ability to do these things—we are seeing that other physicians begin to observe what those selected physicians are doing and how they are practicing medicine, and throughout—this takes some time, but it is sort of a peer watching a peer, and what is it about these physicians that is causing them to be rewarded. This is truly nothing short of a revolution.

Senator WELLSTONE. Again, I would commend Blue Cross-Blue Shield for what you are doing. What I keep hearing in the cafes around the country is stories from individuals who are having a heck of a time negotiating through the "market" with insurance companies, or people who find that the businesses they work for 1 year have one plan and then have dropped it because of another plan, because premiums go up and up and up.

I'm sure there are models, and that's what I like about what you said, but I have the impression that right now what is happening around this country is not working, and it is not just not working for low-income people but for the vast majority of people.

Ms. LEHNHARD. Well, I think it is working, and I think both of us can give you figures from companies——

Senator WELLSTONE. What's working?

Ms. LEHNHARD [continuing]. The ability to control cost, if you look at it on a case-by-case basis. It does take time for it to spread to smaller employers. I think what you have to realize, though, is that total costs are going up. Nothing is going to flatten the curve. It is a question of how much we can reduce the slope of that curve over time.

Senator WELLSTONE. This is frustrating, but I must leave. Thank you very much. I have a lot of other questions, and there may be follow-up.

Let me ask Mr. Schramm a question or two. I want to refer to—so I'll read it—a CRS report that noted that competition among insurers in some markets has become one largely based on risk selection—and I want to focus on this because this is what I hear from people back in Minnesota all the time—and not on the basis of efficiency or service to the customer.

I want to ask you whether or not this doesn't really amount to insuring the people who don't need health care and not being willing to insure the people who do need health care. We have heard a lot about people with prior conditions who have no health insurance. I think this is a real issue with the health insurance industry right now, and I want to get your response.

Mr. SCHRAMM. Sure, it is. I think the conclusion they draw is correct in certain markets, that the conclusion of CRS would typify the situation.

I think this industry and certainly this industry association appreciated that 4 or 5 year ago when we began our long trek that has resulted in our proposals for reform of this situation. Our view, the board of the HIAA, which represents 300 companies that write insurance on 95 million people, is that we ought to have at the State level regulations that would in fact forbid competition on

risk, and that the industry is best operated when we compete over price and efficiency and service.

Senator WELLSTONE. For me, as I leave this hearing today, I really have very much appreciation for your response. I put the question to you because I have such respect for your organization, and I wanted to hear from you as a spokesperson on this, because I think this is one of the things that upsets people the most; they just feel that this is kind of a perverse effect of at least part of the way people are insured or, more importantly, not insured. So I very much appreciate the position that you have taken on this.

Mr. SCHRAMM. Senator, it upsets us enormously, and if I could go back to your point about what you hear in the cafes, there are two sets of bargains going on. What you hear in the cafes is the fallout of people who are caught in the bargain between employers and insurers. That's a very efficient bargaining situation. There are many employers who are changing on an annual basis. We believe that that is by itself symptomatic of things that aren't working well in the insurance area.

The other bargaining is what goes on between insurers and providers, and that's really where the issue should be going; how we get medicine and hospital care to the people we insure. That's where all these structural things are joined, and that I think is essentially what the problem is.

All that you see and all that you hear about in terms of competition over risk, for example, the high velocity of changing of the carriers, many of the problems you have seen in Minnesota, are driven by the fundamental problems of too much supply and our inability to do anything meaningful about that. And until we tackle that problem, the fundamental insurance problems that you talk about, be they in the public or the private sector, will not be changed.

Senator WELLSTONE. I would like to thank you. I think there are going to be follow-up questions from staff if you'd be willing to stay a bit longer. You've got much more to offer than I was able to solicit in just a few questions, and if you have a little more time, we'd appreciate it.

Thank you very much.

Mr. N. EXON. [Staff] You have been very patient, so I will just take a few more minutes.

Mr. Schramm, I just wanted to follow through some of the reasoning in your testimony. First of all, I was not clear on reading the testimony—does HIAA support the goal of universal coverage?

Mr. SCHRAMM. Yes.

Mr. N. EXON. And I assume—well, it goes without saying that you support maintaining and expanding the role of the private insurance system as a means of providing that expended coverage.

Mr. SCHRAMM. Yes.

Mr. N. EXON. I guess I find it hard to reconcile those two goals with your general objections to our "pay or play" approach. You have not historically favored a mandate on employers to provide health insurance. Has that position changed?

Mr. SCHRAMM. No.

Mr. N. EXON. Well, if you don't favor a mandate or a "pay or play"—and this is a problem I have with many of the predeces-

sors—how can you possibly have universal health insurance coverage while maintaining an employment-based private insurance system?

In other words, if we have a public plan or some public financing mechanism to provide coverage, to subsidize coverage for people who do not currently have insurance, how do you keep employers from taking advantage of that system by dropping the coverage they now have and allowing the taxpayers to pick up coverage for workers who are currently insured?

Mr. SCHRAMM. Well, David, I think there are two facets of what you see as—I think—not to characterize your question—but it looks like an irresolvable conflict to you. The issue basically is that we believe our approach to universal coverage is to make the market open. We have not done that yet, and I think we can't reach the conclusion—that it is the second objection we have—that this cannot operate without the approach taken in this "pay or proposal" until we have in fact tested with an open market.

Now, I should say in terms of universal coverage that such a plan, with our proposals for expanded Medicaid, universal requirements of Medicaid throughout the country, reestablishing Medicaid at a serviceable level with the buy in/buy out provisions, which you know we stand for in terms of moving up to 150 or 200 percent of poverty, and opening the market through our access proposals or small group reform proposals, will go a very long way. I mean, I think there probably would be—and I would be subject to challenge on this, and I don't have an adequate answer—there is always going to be some group and some frictional situation which would not be covered at any given time.

The problem, however, it seems to me is the approach taken here, as I have outlined in our testimony, sets this industry up for demise. I guess if there is an irresolvable conflict, that's what it is. The program that is established in this legislation essentially subsidizes the public delivery of insurance. We cannot compete against the government, never could and never will be able to.

Mr. N. EXON. Well, Carl, the bill really moves from a situation which guaranteed preservation of the private insurance system, as in the previous version, which provided a mandate on employers and said we'll have a public program for people who don't have an employer to provide coverage, we'll have a mandate on employers who are not currently providing coverage so that they will all provide coverage for their employees, so we'll have two segments—something for the unemployed, which is public, something for the employed, which is private. We were criticized extensively on that, on the grounds that it would be too burdensome for employers of low-wage labor, where a mandate would represent a significant percentage increase in total compensation.

We tried to respond to that by saying all right, for those people who have lots of low-wage labor, we will allow this option to buy into a public program by paying a percent of payroll. Percent of payroll is set in the legislation in a way that is not supposed to discourage private coverage or cause an exodus to the public system; it is simply set at a level that is supposed to provide a subsidy for the cost of coverage for employers who have low-wage labor, but at the same time, requires a continuing employer contribution and in-

vestment in the cost of coverage for the employees to prevent the very thing that you are concerned about, which is an exodus to the public program because it is available without any constraints, any cost pressure by employers. And I just don't understand how you would think that if we don't have a continuing employer requirement to put in place a program that is really going to provide coverage for people who don't have it now, how you are going to stop shifting of coverage from employers to that public plan, unless employers have some obligation established in statute.

If I have missed something, I'd like you to tell me about it.

Mr. SCHRAMM. No, I don't think you have missed anything, and I appreciate full well the vigor with which some people have fought the question of the mandate, which you have wrestled with over the last couple of years.

Now, I can only speak for the position of HIAA, and our position is that as a first step we must open the market for access and restore Medicaid as a first step. I think then there is a question in front of us, a demonstrable, empirical, testable question, which is does the phenomenon of uninsured change as a result of those steps in any marked, significant way. If not, it seems to me the stage is set then for a different discussion, or the first discussion, or the right discussion.

The timing from our perspective is then as to whether or not the discussion ensues as to the mandate question.

Mr. N. EXON. I think our position is that there is no question that expanding Medicaid will expand coverage; more people will get insurance. But you multiply the cost if you have to pick up those low-income people who are currently employed without any employer contribution, and of course, I think you would say that after you do those steps there are still going to be a very large number of people unemployed because after all, 40 percent of the people who are uninsured today have incomes that are more than 200 percent of the poverty level; 60 percent are not poor. And I think the American people want the security, as citizens of every other country have, of knowing that if they lose their job, or if they change jobs, if the situation changes, they can be sure that they will have insurance coverage from some mechanism, not necessarily wedded to the mechanism in this bill, but something that guarantees insurance coverage for all.

Let me ask both of you—I must say I am still confused by the discussion of why there is a conflict between all-payer rate-setting, which our bill does not quite do, but it obviously has some mechanisms that incline in that direction, and managed care. It has always seemed to me that rate-setting works on the price side of the equation and that managed care really works on the effectiveness and efficiency of care and the volume side of the equation. I wonder if either of you could comment on that.

Ms. LEHNHARD. We think they are fundamentally incompatible. As I mentioned, we may in fact want to pay some physicians more to put them in a network. We know that overall their utilization is lower. An all-payer system will essentially ratchet down on everyone, leave very little room to negotiate underneath that, and we don't think will adequately reward physicians that we want to put

in the networks and take advantage of their good utilization and high quality.

Mr. N. EXON. My understanding of the way most networks are formed now is not that they pay a higher rate provided they sign up—in fact, many of them pay a lower rate—it is more the offering to the provider that you'll have sufficient volume of cases; is that wrong?

Ms. LEHNHARD. Currently, you are right. You don't go out and offer a physician a higher rate. You may offer him a capitation amount that in total is higher than his current income.

Mr. N. EXON. Well, it does seem to me that there ought to be some way where you have an innovative payment mechanism of maybe excluding it from the rate-setting. Is that not something that we could figure out a way to do?

Ms. LEHNHARD. I guess it is very difficult for us to see an all-payer system as just a ceiling and not a floor. Both of us have talked about the most fundamental problem here which is the excess capacity. I think it is only through the negotiations based on price and utilization, particularly price on the institutional side, that you are going to get rid of some of that excess capacity. Occupancy rates of 50 percent just aren't necessary.

Mr. N. EXON. Well, if a facility is not cost-effective, and people sign up with managed care, I presume they won't direct them to that facility, and ultimately it will close. If it is getting the same rate as everybody else, it won't be able to cut its costs——

Ms. LEHNHARD. Not if the rate is covering their cost of operation.

Mr. N. EXON. If you have an individually-organized system as opposed to a formula rate-setting, as in the Medicare program.

Let me just ask one more question with regard to the issue of community rating, Carl. HIAA has a proposal on the table which moves closer to community rating, although it is obviously a long way from it, in the sense that it puts bands around the amount the insurer may adjust rates based on demographic factors and on risk, health status.

I guess it actually does not limit the adjustment for demographic factors, is that right, but it puts a band around the risk adjustment.

We have looked at that, and it looks to me like if you are in the small business market and you have the misfortune to be in one of those expensive demographic categories, and you add on the risk adjustment that is allowed, you can't possibly have affordable insurance.

We took our basic health plan, which is costed as having an employer cost of about $1,300 per year, and we looked at some adjustments that were supplied to us, that you would make for an older age group and soon, geography, industry, that would all be allowed under your plan, and we came out with a per worker cost for a small business that just happened to have an older work force, was located in a high-cost area of a State, primarily female employees, in an industry that might have a high risk profile, with people not in good health, and we came out with a figure of $6,200 per worker.

Are we making a mistake in the calculation, or does that sound like a plausible adjustment up of the range allowed?

Mr. SCHRAMM. I don't know if you are making a mistake in your calculation. I will say that it is in the realm of the plausible that the interplay of a number of variables, if you array them in a certain way, may in fact get you to being significant multiples of a variance from the average band rate. That is a problem our technical committees are cognizant of and are looking at right now.

Mr. N. EXON. Are you wedded to that level of adjustment? Is that something you could conceivably discuss shrinking?

Mr. SCHRAMM. I couldn't speculate on that right now. I might say, though, just to put this in perspective, as is always our attempt, that the existence of that, which we believe is a technical problem that can be solved, in certain cells where the "n" gets very small, is much more important for us to worry about solving that from our perspective than saying that because that exists for "x" numbers of people in a cell where the cacophony of variations on demographic and illness factors, geography factors and such creates a real aberration in rates. That is not enough to ever suck us into the vision of community rating.

My view, as you know, David, is that there is from my perspective a historical warp around the concept of community rating. I have often thought of it in terms of that it has a romantic life of its own in the old-style vision of romantic novels.

When Blue Cross, which established essentially the community rating structure out of whole cloth—it did not have in the annals of insurance a precedent—and HIAA, which really brought a P&C rate theory to the market in the Forties—when this view has triumphed and worked so well for so long, when both of us say in unison that to go back to some vision of community rating would have perverse effects on exactly what the problem is that we seek to change, there has got to be something to this.

Mr. N. EXON. I don't want to get hung up on the label of community rating. What we are talking about is what are the permissible adjustments of cost reflecting experience, and how much are you going to try to spread costs against large numbers of people as opposed to trying to insure people at exactly what you think it will cost them, which means that the guys who have bad health experience or are aged or in high-cost areas pay more than they can ever possibly afford.

So it is not a question of the label of community rating. The fact is we do have something that is very close to experience rating in the small business insurance market, and now it has fallen apart. It is a disaster, as I know both of you recognize. And the question is how we can adjust it closer to a more appropriate risk spreading mechanism.

That's really what I am asking is as I look at what you have proposed it looks to me like there is too wide a range, that some people are going to be in an absolutely untenable position. The question is whether we can narrow that, and I guess what you are saying is maybe, that you have to take a look at it from a technical point of view.

Mr. SCHRAMM. I guess what I'm saying is that we appreciate exactly the phenomenon your little drill with a hypothetical case produces, and our technical groups made up of actuaries understand

that, understand the problem, and are seeing if we can't come up to a solution.

I might say I think your advice in terms of labels is well-taken. It was the practice widely in our industry, virtually universally, 10 years ago to essentially operate on an implicit book rate that took very little cognizance of variations from a case-to-case basis, and I think in many regards the path we are on in terms of establishing these rate corridors with stricter limitations, our consideration of exactly the hypothetical existence of the case you point out from your exercise, suggests that the gravement and the spirit of these reforms are essentially to move us back to the position we were in a decade ago.

Ms. LEHNHARD. David, I would just follow up on that. Really, what we are all looking at, as you say, is how fast can you redistribute the cost of unhealthy groups to healthy groups. I think we have to be very careful, take small steps, or what you could have is immediate reaction of the healthier groups saying, "If this is reform, thank you, but no thank you; we liked it the way it was before," and have an outcry of the small group market. And in fact we are beginning to hear from some State association groups who are in fact worried that their rates will go up, and I think you actually have gone further than some who have put a pure community rate out, so I think you have begun to recognize that you can make these adjustments overnight.

Mr. N. EXON. Well, one answer to the problem is a shifting amongst companies, which could leave a company which starts out with a bad risk, which I know you are very concerned about, in abeyance.

The other question is what happens to average rates in a situation when you bring people in, and presumably the ones who buy immediately if you open it up are those who are high-cost, who have been excluded because of their health status. That is why we think that a mandatory system, coupled with insurance reform, works a lot better because then you are bringing in not only those who would have bought health insurance because they were in bad health but couldn't because nobody would allow them to; you also bring in lots of young, healthy workers who don't have it because they may not be terribly interested, and their employer may not be willing to pay for it. So that on balance, you may not have worsened the risk pool at all.

I thank both of you very much, and I appreciate your testimony.

[Additional statements and material submitted for the record follow:]

PREPARED STATEMENT OF MS. VIRGINIA MONTES, GOVERNMENT RELATIONS, NATIONAL ORGANIZATION FOR WOMEN

The National Organization for Women acknowledges the efforts of the sponsors of S. 1227 in their attempt to provide for basic health care for all Americans. As the sponsors have indicated, the bill is designed to provide for basic health services, either through employer contribution to insurance coverage or other health care service, or through a public program called Americare. The bill also focuses on controlling the cost of health care and provides special provisions to address the problems of small businesses. The effort to provide for access to health care for all Americans and the attempt to contain the costs of these services should be applauded.

American health care has risen far beyond the average cost of living, year by year. We now have a society where as many as 25–30 percent of the citizens do without health services. Many of those without access to health care are women and minorities. It is crucial that Congress address this issue.

However, we see S. 1227 as only a beginning attempt to address the health needs of the citizens of this country. And even in this beginning attempt there are key areas, especially of concern to women, minorities, and the poor that are not fully addressed.

The fact that the bill is based on insurance coverage will insure, we believe, that some folks will not fit neatly into any part of the proposed program. The reasons are varied. They may include inability to comply or understand the government bureaucracy, limited ability to meet monetary restrictions, and unavailable coverage for necessary and preventive services for a specific patient's needs.

Under employer plans, employees will be required to pay part of the premiums for the plan and some co-payments. A $3,000 threshold is required before catastrophic coverage of care takes over. Under the Americare plan, workers whose income fall between 100 to 200% of poverty will be required to pay a premium on a sliding scale. Many of these persons in the income category may have limited ability to meet such requirements. These are the person often referred to as the working poor. Some of these are people who are among the increasing number of folks who work day to day but are still defined as homeless because of the inability to afford permanent housing. Many of these are minorities, and an overwhelming number of them are women, whose numbers are increasing in today's economy.

The bill requires that programs developed by employers, and the Americare program, offer a minimum benefit package. However, setting a minimum benefit package could result in employers, who now offer more extensive coverage, reducing the coverage presently providing to their employees. Some clear incentives to employers should be considered to insure the bill will not have such a negative impact.

The bill does provide for coverage of some preventive services, such as prenatal care, mammograms, pap smears. However, there is no indication in the bill that this would cover the option of abortion to any woman in the program. Again, this could mean a restriction in services for women. Nor is there any mention that preventive services would include contraceptive services for women or men. Such services, if available, could be beneficial, both as a cost containment measure, and as prevention measure that would decrease more costly services, beyond even the health care system.

The program outlined in the bill provides that employer plans must cover employees working for 17½ hours per week. However, employers only may, but are not required to cover other parttime employees. This could cause particular hardships on women, and those whose income are developed from several parttime jobs. An Older Women's League 1991 report indicated that almost 70% of all parttime workers were women. This provision could especially effect older women (those who are 50 years and older) and comprise 40 percent of women who work parttime.

The proposed bill also includes a waiting period of 30 days. Though this is standard practice for most insurance plans, if this bill is to provide for access for all Americans, then health needs should be covered from day one. Any restrictions as to timelines on coverage restricts access to health care. In addition, though pre-existing conditions are covered, there are again timeline for this coverage. If we are truly working towards a comprehensive plan for all Americans then it must serve the needs of the poorest, whatever their condition, in a timely fashion. Families should not have to be restricted as to when they may start their families, based on their health insurance. Comprehensive programs should not be set in place that may force persons to not provide all the information about their health needs to insure they will have access to needed health services. A program that is comprehensive should provide access for all health services, no matter when you enter the system. Preventive services should include all options and services, including health education, yearly exams, abortions, diagnostic tests, etc.

Positively, the consumer protection in the bill provides for civil actions and an appeal process as well as fines against employers whose actions are deemed negative in their treatment of employees. These provisions of the bill are to be praised and will, we believe serve to protect consumers, improve the present system, and reduce the overall costs of health care, which has been impacted by the rising costs in litigation and technology.

We have some concerns, however, about the Americare plan, which is designed to replace Medicaid (except for the long term care provisions in Medicaid). The plan includes coverage for those with incomes under 100 percent of poverty and a sliding scale for others. It is this latter group which includes a large percentage of women,

particularly single-heads of households. These are women who may not have the resources to pay the sliding scale premiums to insure coverage. What happens to them? Do they go without access to health care? Will they be forced to choose between insurance premiums and paying the rent or the food bill? This happens now. It is not likely that the proposed program is S. 1227 will change the access issue for many of these women and their families.

We are also concerned about the administration of the Americare plan. The program which will be state administered, could result in differential treatment from state to state. Though we know that the framers of the legislation have worked to make sure that this should not happen. If the program is, in any way, reflective of the Medicaid program, this will happen. Southern states, rural areas, and blighted urban areas, which suffer the greatest needs in terms of access and services may get the least coverage. This may mean that those with the greatest needs will have the least resources available at the local level. It may mean that, for the poor, and near poor, we do not have a truly comprehensive national plan, but individual plans by each state meeting a bare minimum national requirement. States truly committed to comprehensive health care will provide expansive services, others will offer on the minimum required. Areas where women and minorities suffer discrimination, limited transportation to health services, a reluctance by providers to participate, and an overall lack of access will continue to be without comprehensive health care.

The encouragement of "managed care" services (such as HMO's) in the cost containment section of the bill is important. However, how one defines "unnecessary and ineffective", health care costs and services should be clearly defined. Such broad provisions could result in certain services not being covered, or eliminated, even when necessary for a specific patient needs.

The bill does provide for some consumer input into Boards that will have the responsibility for overseeing the implantations for the overall programs, and for specific individual sections (such as the small business and state administration). However, that input, at all levels is limited. The Boards will be controlled by providers, including insurance representatives health professionals, and the business community. The Boards have no specified requirement to be reflective of the population being served within a state or in the country as a whole. The state and national Boards could, theoretically, be all-white and all-male. Some measure should be made, that is more than a general statement, to insure equal representation of all the population segments, including women and minorities. Consumers should have an equal voice and equal voting power to interest groups who control the services and the economy of the health care system. This must happen if we are to be sure that programs will work to provide services equally to all Americans.

Prepared Statement of a Coalition of National Organizations of Mental Health Professionals

On behalf of: American Academy of Child & Adolescent Psychiatry, American Association for Counseling and Development, American Psychiatric Association, American Psychological Association, Child Welfare League of America, Family Service America, Federation of Families for Children's Mental Health, International Association of Psychosocial Rehabilitation Services, Mental Health Law Project, National Association of School Psychologists, National Association of Protection and Advocacy Systems, National Association of State Mental Health Program Directors, National Depressive & Manic Depressive Association, and National Mental Health Association

We thank you, Mr. Chairman and Members of the Committee for this opportunity to testify concerning S. 1227 and the special needs of people with mental illness for acute health care coverage. We commend all of the sponsors of S. 1227, and particularly Senators Mitchell, Kennedy, Riegle, and Rockefeller, for their leadership in recognizing that mental health coverage is essential in any national health care access legislation.

This testimony is offered on behalf of a coalition of national organizations of mental health professionals, providers, advocates and consumers who have long been concerned about the failure of our health care system to provide the basic elements of acute care services to people in need of mental health services. The organizations which have endorsed this testimony are: American Academy of Child & Adolescent Psychiatry, American Association for Counseling and Development, American Psychiatric Association, American Psychological Association, Child Welfare League of America, Family Service America, Federation of Families for Children's Mental Health, International Association of Psychosocial Rehabilitation Services, Mental Health Law Project, National Association of School Psychologists, National

Association of Protection and Advocacy Systems, National Association of State Mental Health Program Directors, National Depressive & Manic Depressive Association, and National Mental Health Association.

The testimony reflects the general position of the Associations listed above. Individual associations may also submit separate statements addressing more specific issues.

I. Current Inadequate Coverage of Mental Health Services

A. Private Health Insurance

Obviously, the 37 million Americans without public or private health coverage have protection against neither physical or mental illness. And, among the 153 million people with private insurance plans in 1986, the access problems for people in need of mental health services is far more difficult than for those seeking physical health care.[1]

—Although 99 percent of individuals and their families had coverage for inpatient mental health treatment, only 37 percent had the same coverage as for treatment of other illnesses. Over 60 percent had either fewer days of coverage or a special annual or lifetime dollar maximum for mental illness. Further, the coverage in 1986 represented a deterioration from 1981 when 58% of persons with health insurance had equal impatient mental and non-mental health coverage.

—Only a small percentage (10.7%) of all participants were covered for partial hospital (day or night) treatment.

—For outpatient benefits, the coverage limitations were even more stringent. While 97 percent of persons with private health insurance had coverage for outpatient mental health benefits, only 6 percent had coverage equivalent to coverage for other illnesses. In general, multiple limits existed on number of visits covered (33%), total dollars reimbursable (68%), and/or percentage of allowable charge paid (48%)

—For many participants, the outpatient dollar limits were severe. For example, only 24% of the plans reimbursed at higher than 50% of allowable charges. For participants in plans with annual dollar limits, over 77% had payment limits of $1,000 or less per year. While a majority of plans provided over thirty outpatient visits per year, when combined with limits on payment per visit and/or maximum annual reimbursement, this coverage was significantly less than for other conditions.

—Many private plans have "pre-existing" condition limitations or exclude "conditions not amenable to short-term therapy." [2]

In sum, inpatient and outpatient benefits in private insurance for mental illness are far less comprehensive than those for physical illness. Maximum benefits are lower, deductibles and co-insurance higher and the percentage reimbursed substantially smaller.

B. Public Health Programs

The two national programs providing access to mental health services are Medicare and Medicaid. Each covers a specific and limited segment of the population and neither provides comprehensive service coverage.

The *Medicare* program contains a number of special limitations relating to mental health services. Part A of the program contains a life-time limit of 190 days of care in a psychiatric hospital. Care in a psychiatric ward of a general hospital, however, is subject to the same limits as any other admission for non-mental health care. Under Part B, outpatient psychotherapy services provided in an individual practitioner's office or as part of an organized care setting such as a community mental health center is covered, but a 50% copayment is required from the patient. Physician services, including medication management for persons with mental illness, are covered without limit with a 20% copayment requirement. Part B also covers partial hospitalization services when provided as part of the program of an accredited hospital or qualified community mental health center.

In addition to almost everyone over age 65, persons with disabilities who have been on the SSDI roles for over two years are eligible for Medicare. An estimated 15

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[1] The data in this section is adapted from *The Coverage Catalog*, 2d edition, prepared by the Office of Economic Affairs of the American Psychiatric Association, American Psychiatric Press, Inc. 1989. It utilizes data from the 1986 Employee Benefits Survey conducted by the Bureau of Labor Statistics, as well as APA survey of 300 employer-sponsored benefit plans and Health Maintenance Organizations (HMO) in1987 and the Federal Employees Health Benefits Program (FEHB) for 1989.

[2] Plan for Kaiser Permanente, Mid-Atlantic Region, quoted in *The Coverage Catalog*, p. 173.

to 20 percent of the 2.8 million "workers" receiving SSDI benefits are classified as having "mental, psychoneurotic and personality disorders." [3]

Services for persons with mental illness through the *Medicaid* program defies easy generalization. We can say that overall the program includes less than 45 percent of all persons below poverty and that its full potential for services to mentally ill people has nowhere been achieved.[4] While the Medicaid program will reimburse states for a broad range of services, many do not take advantage of options available in the law. As of February 1991, 23 states provided rehabilitation services specifically to persons with mental illness, 15 states provided personal care specifically to persons with mental illness and 26 states provided target case management services to persons with mental illness and 26 states provided target case management services to persons with mental illness.[5]

States have discovered "legal" means to limit even the mandatory hospital inpatient and physician benefits for persons with mental illness. In addition, under the law persons between ages 22 and 64 are not eligible for inpatient services in an institution for mental diseases (IMD) defined as a hospital, nursing home or other institution of more than 16 beds primarily engaged in care, treatment or diagnosis of persons with mental diseases. Such patients would be eligible for services in the psychiatric ward of a general hospital. In almost all states the mandatory outpatient hospital and optional clinic services have become the principal settings for provision of outpatient mental health services. Partial hospitalization, psychosocial rehabilitation, day treatment and case management are also financed through outpatient hospital and clinic services in less than half of the states.[5] Medicaid also provides coverage of prescription drugs, including psychoactive drugs, which is a major benefit to persons with mental illnesses. In all states payments for services are below market rates creating a significant disincentive for many hospitals, physicians and other mental health professionals to treat Medicaid patients.

II. Scope and Prevalence of Mental Illness

Mental illness knows no class, sex, race or age limitations. Recent data from the National Institute of Mental Health provides a picture of the breadth and impact of mental illness in the United States, particularly among the working age population.

—In any six month period, approximately 29.4 million adult Americans (18.7 percent of the population) suffer from one or more mental disorders ranging from mild to serious but for whom mental health intervention is appropriate.
—People aged 25 to 44, people in their prime working years, accounted for the largest percentage of admissions to inpatient psychiatric services in 1980.
—Suicides by persons under age 35 was the third leading cause of death for this age group in 1982 and between 1958 and 1982, the number more than doubled.

The locus and nature of mental health care has changed markedly over the 14 years from 1970 to 1984. Inpatient beds per 100,000 people decreased 56 percent, but inpatient treatment episodes decreased only 3 percent, indicative of significantly shorter inpatient stays. Concomitantly, outpatient care in organized care settings (i.e. excluding patients served by private practitioners), increased over 135 percent per 100,000 population during the same period.

In 1980, total expenditures for mental health care were estimated to be between $19.4 and $24.1 billion, representing about 8 percent of all expenditures for health care.[6]

III. Mental Health Benefits in S. 1227

The approach taken by S. 1227, HealthAmerica, represents good national health policy. For a nation as rich as ours to have 37 million Americans—including 12 million children—without adequate or regular access to health care is no less than a

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[3] *Background Material and Data on Programs within the Jurisdiction of theCommittee on Ways and Means*, 1989 edition, WMCP: 101–4, p. 59. The data indicates that about 11 percent of all new disabled worker beneficiaries between the years 1970 to 1982 were mentally impaired. The percentage increased rapidly thereafter rising to 18% in 1985 and 23% and 22% in 1987 and 1988 respectively. Since people with mental illness are likely to be younger when they enter the roles and to have a more normal life expectancy than persons with physical impairments, they make up a growing proportion of the current SSDI population.

[4] While somewhat dated, the most completed review of Medicaid mental health coverage can be found in *Mental Health Benefits Under Medicaid: A survey of the States. January 1984*, compiled by Gail Toff for the Intergovernmental Health Policy Project, Washington, D.C.

[5] *Financing Community Mental Health Services Through Medicaid for Persons with Serious Mental Illness.* February 1991, National Association of State Mental Health Program Directors Study 90–679.

[6] *Mental Health United States, 1987.* National Institute of Mental Health, Rockville, Md.

national disgrace This bill would close two-thirds of that gap by guaranteeing to 23 million workers and their families through their employment access to a fixed package of health care services. The non-working, uninsured population would be covered through a public program. Overall, the bill would assure all Americans access to appropriate health insurance care. We applaud the objectives of the bill and support its enactment as we indicate in this statement.

Our comments address the aspects of the bill directly related to the needs of persons with mental health care needs; and do not address the financing aspects of the bill. We must point out, however, from the point of view of people with mental illness and others who have reason to seek mental health services, it is unfortunate that the bill provides less coverage for treatment of mental impairments than for physical ailments.

But given the importance of the legislation to 37 million people who have no coverage, neither mental nor other health care, we support the legislation. But we will continue to work for mental health coverage in insurance plans, both public and private, with limitations no more restrictive than those for other health conditions.

The bill contains a number of provisions which are extremely beneficial to people with mental illness and others who have reason to seek mental health services, including provisions to:

—Coverage of 45 days of inpatient hospitalization and 20 visits to a qualified mental health professional for psychotherapy;

—Permit a "trade-off" between days of hospitalization and outpatient visits, as long as the insurance plan provides some hospital inpatient care and some outpatient care. Further, trade-offs between days of inpatient care and partial hospitalization or day treatment services for adults and children would also be permitted. The objective of the trade-offs is to encourage the use of the least restrictive treatment setting based on the needs of the patient.

—Prohibit insurance carriers from excluding people from coverage because of preexisting conditions. The presence of a chronic handicap, such as mental illness, has been used by carriers to deny both coverage and reimbursement for mental illness and other chronic disorders and conditions.

—Enhance access to services by permitting a broad range of mental health professionals licensed or certified by state law and operating either independently or in clinics or centers to provide mental health care.

—Require all insurance plans to cover the basic mental health benefit package in the bill. It does not permit carriers to eliminate one benefit for another not included in the bill. Without this limitation, the mental health benefit could be traded away by insurance carriers for other benefits. Often individuals wanting mental health benefits are intimidated from requesting them from their employer because of the stigma attached to mental illness in our society. Sometimes promotions are lost and jobs are jeopardized by a worker's admission to needing mental health services. Stigma also encourages other to assume they will never need mental health services. For these reasons, mental health benefit needs to be protected.

An adequate national mandated minimum benefits law is far preferable (in terms of uniformity of minimum benefits) to a patchwork of state mandate laws. Even the most generous state law does not help workers whose employers do not offer a group health plan or who cannot afford to buy their own. Further, mandated state laws are not universal, less than half the states have any law on the subject, and more than half of these require only that health insurance policies offer mental health benefits, not that the group or individual must accept them. However, we also support a waiver for those states whose state laws mandating health insurance coverage are broader than the requirements in this bill.

An additional benefit which would be extremely important for persons with mental illness include coverage of prescription drugs. Psychopharmacologic drugs are often essential to stabilizing and treating persons with mental illness. We note that S. 1227 authorizes the Secretary to conduct a study of the feasibility of covering prescription drugs under this plan, and will monitor that activity with great interest.

Other important mental health services should also be mentioned in connection with this bill. These are case management services, psychosocial/psychiatric rehabilitation services for adults, and specialized services for children. These are all vital components of care for persons with serious mental illnesses or children with emotional disturbance. Psychosocial/psychiatric rehabilitation is a program of rehabilitative services focusing on the development of independent living and vocational skills and which provide supportive social programs including peer support. These

rehabilitation programs have been shown to be cost-effective in providing community care to adults with serious mental illness.[7] Case management is a service which helps ensure that an individual receives the appropriate range of supports necessary, including mental health treatment, income, housing, etc. As appropriate, each individual with a serious mental illness should receive case management services to help insure that an adequate treatment plan is developed and implemented and that services are coordinated. For children with serious emotional disturbance, access to day treatment and other intensive programming provided by states through the rehabilitation option is critical.

While the mental health benefits in S. 1227 are focused primarily on mental health treatment services, these additional services are essential to assisting adults to regain, or maintaining, their functioning so that they are able to live independently or to return to work, and in addressing the needs of children at high risk of future life-long disabilities. Given the focus of HealthAmerica on acute care needs, we are not urging inclusion vi these services in the basic benefit at this time. However, under the public program it is critical that individuals continue to have access to case management, psychiatric rehabilitation and other services now covered under state Medicaid plans.

We are pleased to note that for children, the public program would ensure access to the range of physical and mental health services which are provided through the Early, and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The mental health component of EPSDT is of growing importance in identifying children with major emotional problems early in life and providing appropriate follow-up care.

Under S. 1227, all persons not protected by employment-based coverage would be covered under the public plan, and in addition persons with incomes below the poverty line will have access to optional Medicaid services that the state choose to provide.

We are concerned that these eligibility provisions may work to the disadvantage of sizable numbers of individuals with disabilities who are currently eligible for Medicaid services because they are receiving Supplemental Security Income (551) benefits. Through 551 work incentive provisions, these individuals can earn up to $899 a month, 63% above the poverty line (the poverty definition is $552 per month), before their 551 benefits are completely exhausted. Even then, these individuals who are working despite their disability retain their Medicaid entitlement.

While the SSI working population would continue to be eligible for HealthAmerica, they would lose their eligibility for the Medicaid optional services, (including those described above as being important for persons with mental health care needs) if their income exceeded poverty.

Two other groups who may be disadvantaged by the bill, are the medically needy population who are eligible in some states up to 133% of poverty and persons whose medical bills are so high they "spend down" into Medicaid eligibility.

We would appreciate the opportunity to work with the Committee to assure that legislation does not inadvertently hurt people with serious medical needs who now have coverage through Medicaid.

Conclusion

The problems faced by Americans in obtaining adequate and affordable health insurance for their physical health needs are also faced by individuals with mental illness. Further, people with mental illness have the additional obstacles of inaccessibility of services, discrimination in coverage policy, and historic emphasis upon the public psychiatric hospital as the primary locus of care.

The enactment HealthAmerica would represent the most important advance in national health policy since the passage of Medicare and Medicaid in 1965. It will provide access to health care for 37 million persons now without such access. It strikes the necessary balance between the access needs of people without health insurance coverage and the costs to business and the public of meeting those needs.

We look forward to working with the Committee to ensure action on S. 1227.

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[7] Bond, Gary, "An Economic Analysis of Psychosocial Rehabilitation," Hospital and Community Psychiatry, April 1984; and Weltman, Poveromo, Lori and Nofi, Ralph, "Impact of Community-Based Psychosocial Treatment on Clients' level of Functioning," Hospital and Community Psychiatry, May, 1988.

Prepared Statement of the Health Task Force of Consortium for Citizens with Disabilities

On behalf of:
AIDS Action Council
American Academy of Physical Medicine and Rehabilitation
American Association for Counseling and Development
American Association of University Affiliated Programs
American Civil Liberties Union
American Congress off Rehabilitation Medicine
American Foundation for the Blind
American Occupational Therapy Association
American Speech-Language-Rearing Association
Association for Retarded Citizens of the United States
Epilepsy Foundation of America
International Association of Psychosocial Rehabilitation Services
Learning Disabilities Association
National Alliance for the Mentally Ill
National Association of Protection and Advocacy Systems
National Association of Private Residential Resources
National Association of Rehabilitation Facilities
National Association of Developmental Disabilities Councils
National Association of State Mental Retardation Program Directors
National Easter Seal Society
National Head Injury Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Parent Network on Disabilities
National Recreation and Parks Association
National Rehabilitation Association
Spina Bifida Association of America
United Cerebral Palsy Associations, Inc.

INTRODUCTION

Mr. Chairman and Members of the Committee. The organizations represented in CCD's Health Task Force appreciate the opportunity to express our support for your efforts and our concerns about S. 1227 from a disability perspective. The time is ripe to sharpen the debate for national health care reform. We commend Senators Mitchell, Kennedy, Riegle, and Rockefeller for taking the leadership to introduce legislation that will focus this debate.

The Consortium for Citizens with Disabilities is a working coalition comprised of over 70 consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and their families. This statement is presented on behalf of 28 national organizations who comprise the overwhelming majority of CCD Health Task Force members. The more than 43 million Americans with disabilities include individuals with physical or mental impairments, conditions, disorders, severe acute or chronic illness which limit or impede their ability to function. Such disabilities may occur as a result of disease, injury, sudden trauma, aging, or congenital anomaly. One of the reasons for the passage last year of the historic Americans with Disabilities Act was to finally recognize not only the existence and importance of these millions of Americans with disabilities, but also to ensure their individual civil rights.

When one considers the numbers and range of individuals covered by the definition of disability, it is no wonder that the issue of access to appropriate, adequate, and affordable health care and related support systems is of such critical importance to the CCD. In fact, while 43 million is the official number cited for persons with disabilities, the CCD believes that, in actuality, this number is an under-estimation. Therefore, it is also no wonder that any discussion of reform of the nation's health care system must include not only the generic consumer perspective but also the unique perspective of consumers with disabilities. It is the belief of the CCD that addressing the disability perspective in the current health care reform debate will ultimately benefit all Americans.

In considering the issue of health from the disability perspective, it is essential to re-focus our conception of what being "healthy" really is. For so many people with disabilities health is determined by functional capacity. It is the ability to maintain or increase this functional capacity that is often the measure of the person with dis-

abilities opportunity to live an independent life and participate as fully as possible in the life of the community. True realization of the rights now guaranteed by the ADA and other important pieces of civil rights legislation, unfortunately, will continue to be limited as long as people with disabilities do not have access to a seamless array of life-long health, personal, and support services.

The CCD has determined that any effort to reform the nation's health care system must be built on five basic principles: non-discrimination, equity, comprehensiveness, appropriateness, and efficiency. Only in this manner can we ensure that national health care reform efforts take into consideration the needs of Americans with disabilities.

PRINCIPLES

The CCD believes that any ultimate solution to the health care crisis must be based on the principle of non-discrimination ensuring that people with disabilities of all ages and their families have the opportunity to fully participate. The CCD would define a successful health care system as one that offers a comprehensive array of health, rehabilitation, personal, and support services, as well as a system that ensures that these services are appropriate in that they are provided on the basis of each individual's need, personal choice, and situation. In addition, any truly effective solution must be equitable ensuring that no group of individuals bears a disproportionate burden. Finally, the CCD asserts that an effective and accessible health care system must be efficient ensuring that system resources are utilized to meet health care needs. The CCD strongly supports the right to health care for all persons regardless of income or health status.

Non-Discrimination: People with disabilities of all ages and their families must be able to fully participate in the nation's health care system.

People with disabilities are often discriminated against in the health insurance marketplace because they are presumed to be high health care users. In fact, most people with disabilities are not sick. Nevertheless, private insurers use medical underwriting practices which are designed to ensure that high users of health care are charged higher premiums, subjected to preexisting condition exclusions, or rejected totally as an "unacceptable risk". Discrimination occurs when a sizable proportion of persons with disabilities who are actually low users of health care are denied insurance or subjected to preexisting condition exclusions. Discrimination also occurs when high users of health care are denied adequate coverage because they cannot afford the premiums or are subjected to limitations on covered services. From a disability perspective, the very practice of experience-rating which ensures that premiums are set on the basis of previous utilization, is a form of unfair discrimination against high users.

Access to health care for individuals with disabilities cannot be considered in a vacuum. Historically, discrimination on the basis of disability has limited opportunities in employment, education, housing, travel, and other aspects of daily life. Now, with rights guaranteed in so many of these areas by the passage of the Americans with Disabilities Act and other important civil rights legislation, there is a growing realization in the disability community that access to health care is a major barrier that threatens to interfere with the attainment of these rights. The CCD believes that the present inability of a substantial proportion of people with disabilities to participate in the nation's health care system at a level which meets their needs is a direct reflection of the continued misperception of both the skills and needs of people with disabilities. Non-discrimination requires that the health care financing system:

—prohibits pre-existing condition exclusions;
—prohibits rating practices that discriminate against higher users of health care;
—ensures that all persons, regardless of income or health status, have access to the all needed health related services;
—provides access without regard to age, race, place of residence, or the characteristics of persons with whom one maintains family relationships;
—ensures continuity and portability of coverage.

Comprehensiveness: People with disabilities and their families must have access to a health care system that ensures a comprehensive array of health, rehabilitation, personal, and support services across all service categories and sites of service delivery.

The CCD asserts that an effective and comprehensive health care system, one that is responsive to the needs of people with disabilities, would provide a seamless array of life-long health related services. Comprehensiveness implies the broadest set of

services that assist individuals with disabilities and their families to achieve and sustain optimum physical and mental function. The terms "health, rehabilitation, personal, and support services", used by the CCD, refers to a universe of services delivered by a range of practitioners in a variety of sites and illustrates the necessary breadth of a health care delivery system that is truly accessible to people with disabilities. Over the course of a lifetime, all people commonly require a broad array of health, rehabilitation, personal, and support services. However, access to the entire array of these services must be ensured for people with disabilities. Often it is the availability of these services that can determine their ability to live independent lives and fully participate in the community. Moreover, adequate access can prevent exacerbation of a small health problem from developing into a larger more costly health problem. People with disabilities would most benefit from a health care system that includes access to:

—preventive services, including services to prevent the worsening of a disability
—health promotion/education services
—diagnostic services
—inpatient and outpatient physician services
—hospital inpatient and outpatient care
—long term care in medical facilities
—long and short term home and community-based services
—prescription drugs, biologicals, and medical foods
—mental health and counseling services
—habilitation services
—rehabilitation services, including audiology, occupational therapy, physical therapy, respiratory therapy, speech-language pathology services, cognitive, vision, and behavioral therapies, and therapeutic recreation
—personal assistance services and independent living services
—durable medical equipment and other assistive devices, equipment, and related services

Appropriateness: People with disabilities and their families must be assured that comprehensive health, rehabilitation, personal, and support services are provided on the basis of individual need, preference, and choice.

Particular attention must be placed on the appropriateness of available services. It is of critical importance to the disability community that full involvement of the "consumer" is assured in all decisions affecting the selection of service, service provider, service timing, and service setting. CCD is concerned that certain forms of managed care create an incentive for under-serving persons with disabilities and often utilize gate-keepers who are not knowledgeable about the special health care needs of persons with disabilities.

The issue of consumer choice and participation has a particular importance for persons with disabilities. While the present acute-care oriented health care system has a tendency to relegate all "consumers" to a dependent status embodied in the "sick role", this indignity is particularly disempowering to persons with disabilities when their chronic health conditions are permanent. That is why the health related services for persons with disabilities must be delivered in a way that minimizes interference with normal activities, and that health care financing policies which govern access to health care for persons with chronic conditions must be sensitive to issues of locus and control.

It is essential that decisions about health care services reflect personal preference and maximum benefit to the individual rather than provider and service setting availability, cost-containment goals, or coverage limits. CCD asserts that meaningful access to health care involves the right of the individual consumer to participate in the decision-making process regarding the provision of needed services and to be educated so appropriate self-care is possible.

In addition, CCD strongly believes that persons with disabilities must be involved in policy decisions that will guide the nation's health care system. An appropriate health care system is one which:

—includes consumer participation;
—ensures consumer choice in relation to services and provider;
—ensures a range of service settings through an integrated delivery system;
—ensures appropriate amount, scope, and duration of services;
—ensures the availability of trained personnel.

Equity: People with disabilities and their families must be ensured equitable participation in the nation's health care system and not burdened with disproportionate costs.

The CCD asserts that equal access to health services will not be readily achievable unless payment for health, rehabilitation, personal, and support services is equitably distributed so that no individual or public or private sector interest is burdened with a disproportionate share of the cost. Because of cost issues, too often people with disabilities and their families have been required to make unfortunate choices between needed health services in appropriate settings and what they can afford. These types of choices obviously do not reflect the principles of non-discrimination, comprehensiveness, and appropriateness of services. Health care reform must ensure that people have access to services based on health care need and not on their employment status or income level. As a group, people with disabilities have lower incomes than the general population and many adults with disabilities and families with members with disabilities devote a disproportionate share of their income to health care and disability related services. An equitable health care system would be one which:

—limits out of pocket expenses and cost sharing requirements for participants;
—provides access to services based on health care need and not on income level or employment status;
—ensures adequate reimbursement for service providers.

Efficiency: People with disabilities and their families must have access to a health care system that provides a maximum of appropriate effective quality services with a minimum of administrative waste.

The CCD is concerned that the current fragmentary system has failed to achieve effective cost controls, or a rational allocation of health resources, and contributes to substantial administrative waste. It is estimated that more than 20 percent of health care expenditures are attributed to administrative costs as 1500 private health insurers require different forms of provider documentation to trace every claim for reimbursement to the utilization by a specific individual with his or her own health insurance plan. In addition, the fragmentary system has contributed to the growth of excess capacity in the health care delivery system, inviting cost shifting, and undermining efforts to achieve effective cost controls. This has reinforced pressures for arbitrary cost containment by limiting coverage in ways that often adversely affect persons with disabilities.

Moreover, health care financing policy has not evolved much beyond acute care, failing to respond to the growing need for preventive care and for chronic health care management which could significantly reduce the growth of preventable diseases.

An efficient health care system is one that:

—reduces administrative complexity and minimizes administrative costs;
—allocates resources in a more balanced way between preventive services, acute care, rehabilitation, and chronic care management;
—ensures the delivery of effective services;
—maintains effective cost controls so that all people can get the health care services which they need.

Based on these "principles", CCD is reviewing various health bills introduced in the 102nd Congress. Below is an evaluation of "HealthAmerica: Affordable Health Care for All Americans Act (S. 1227)" based on the defining principles of a disability perspective.

POSITIVE FEATURES OF S. 1227

The CCD endorses several features of S. 1227. These aspects reflect the principles that must form the foundation of any health care reform attractive to the disability community.

Prohibition of preexisting condition exclusions: The CCD considers the prohibition of preexisting condition exclusions to be an essential change. Persons with disabilities and chronic conditions have historically been limited in their access to health care and options within the health care system.

CCD is very concerned, however, about the small employer exclusion which can deny health insurance to persons with disabilities during the first five years of implementation. CCD opposes any denial of health insurance during the first five years of implementation despite the provision that individuals who have had continuous coverage up until the new plan may have their preexisting condition exclusion reduced by one month for each month of continuous coverage immediately preceding the new health plan. At the very least, CCD recommends that persons with dis-

abilities should be able to buy-in to the public plan before their small employers are required to contribute to their health care.

Nondiscrimination based on family status: Under S. 1227 employers cannot discriminate against any job applicant who has a spouse or child that would potentially incur tremendous health care costs because of any health condition. In the same manner, an employer cannot dismiss an employee on this premise. This is an important protection since the Americans with Disabilities Act does not pertain to employers with fewer than 15 employees.

No limits on amount or duration for most covered services: For most services which health benefit plans would be required to cover, there would be no limits on the amount or duration of services. These covered services include: inpatient and outpatient hospital care, inpatient and outpatient physician services, and diagnostic tests. CCD views as discriminatory, however, the limitations which are imposed on mental health, rehabilitation services, and specified preventive services.

Limit on out-of-pocket expenses: Out-of-pocket payments for covered services under the private, as well as the public plan would be limited to $3,000 per year. For so many individuals catastrophic health care costs place them in financial jeopardy. This limitation offers some assurance against health care bankruptcy.

Federal minimum standards: Recent changes in the private health insurance industry have fundamentally undermined state regulation of private insurance. Since 1989, the majority of persons with a private health care plan are covered through self-insured employers who are currently exempt from state regulation due to a (1986) Supreme Court interpretation of the Employee Retirement Income and Security Act (ERISA) which was not anticipated when Congress established ERISA in 1974. Without Federal minimum standards, private insurers will have difficulty changing their risk avoidance behavior in the competitive health insurance marketplace. Private insurers have preferred State regulation over Federal regulation because they were able to play one state off against another and because the state agencies have generally lacked the capacity to effectively regulate them. Federal minimum standards for both the private and public plans are necessary to provide a protection against this erosion of standard health care.

Enhanced benefits through the new public plan: Providing enhanced benefits to AmeriCare beneficiaries living at or below the federal poverty line is another appealing aspect of S. 1227. These benefits include all services covered under the state's Medicaid plan except for nursing home care, home health care, or inpatient psychiatric services (for persons over 65 years old). States may elect to provide other benefits as well, but no federal matching funds will be available.

The CCD is concerned, however, that low income persons who are insured through a private plan would not be eligible for these enhanced benefits, nor would they be able to opt out of their employer's private plan to avail themselves of the better benefits in the public plan. In addition, persons with incomes above 100 percent of poverty would not be eligible for the enhanced benefits in the public plan regardless of the extent of their disability-related needs.

Preventive services: S. 1227 requires coverage for certain types of preventive services, such as prenatal care and well-baby care provided to children under 1 year of age, well child care, pap smears, and mammograms. In addition, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are covered for low income children under 21 years old through the public plan, and even for low income children on a buy-in basis who are privately insured.

The CCD believes that closer attention should be directed to the preventable acute care needs that are actually the result of underlying chronic health conditions not adequately diagnosed or treated.

Small employer health insurance reform: Recognizing that the principles of insurance are violated most in the small group market, S. 1227 has proposed various small employer health insurance reforms to increase the spreading of risk. These are expected to be achieved through requiring insurers to comply with requirements for guaranteed issue, rating limits, minimum plan period, and guaranteed renewability. It is most significant from a disability perspective that these small group insurance market reforms do NOT exempt the small employer from meeting the Federal minimum benefit requirements.

Nevertheless, CCD is concerned that people with disabilities may still be discriminated against since these insurance reforms do not ensure that all small employers pay the same community-rated premium regardless of the age or health status of their employees and their dependents.

Resource development: S. 1227 authorizes $1.2 billion over 5 years for expansion of community and migrant health centers for both development and continued operation. This earmark recognizes that the competitive health care marketplace does

not ensure an equitable distribution of health resources in low income and rural areas.

However, S. 1227 does not explain how the system would increase the capacity of primary care providers and allied health professionals to be more competent in responding to the health care needs of persons with disabilities—a gap in our current health care system that needs to be addressed.

LIMITATIONS OF S. 1227

While S. 1227 would remove some of the major obstacles to health insurance for persons with disabilities, it is important to consider how this would actually affect the way the health care system responds to the health care needs of persons with disabilities or chronic illness. CCD believes that the following components are essential for a comprehensive approach to health care reform for people with disabilities and their families.

Expanded minimum benefit package: The definition of minimum benefit requirements in S. 1227 ignore many crucial health related services needed by persons with disabilities or chronic illness. Among the health related services which are not included in the minimum benefit package are: (1) prescription drugs; (2) rehabilitation services including audiology, occupational therapy, physical therapy, respiratory therapy, speech-language pathology services, and cognitive, vision, and behavioral therapies; (3) durable medical equipment including assistive devices/technology, (4) long and short term home and community-based services; (5) personal assistance services; and (6) permanent and temporary long term care in medical facilities.

Prescription drug coverage: S. 1227 does not insure prescription drugs in the Federal minimum benefit standard. As recently as 1989, 95% of employees in large and medium size firms have drug benefits according to the U.S. Department of Labor's Employee Benefits in Medium and Large Firms, 1989. The CCD recommends that prescription drugs, including biologicals and medical foods, be incorporated into the minimum benefit package.

However, a prescription drug benefit does not go far enough. Many people with chronic health conditions need protection from insurance companies denying reimbursement for prescription drugs on the excuse that a particular drug has not been approved by the Food and Drug Administration (FDA) for a specific condition. This practice, which is growing under the pressure of cost-containment, jeopardizes essential treatment for many people with chronic conditions. Federal policy is needed to ensure that "off-label" uses of FDA-approved drugs are covered when they are prescribed by a physician and supported by peer-reviewed medical literature.

Finally, people with chronic health conditions also need coverage for drugs which are truly "experimental" whether it is paid for by one's own insurance plan or by a separate public program which is designed to expedite the testing of "experimental" uses of prescribed drugs and other medical procedures.

Outpatient rehabilitation benefits: Many persons with disabilities must access rehabilitation services after being discharged from a hospital to attain the functional capacity, independence and quality of life of which they are capable.

To cover only hospital-based rehabilitation services would mark a significant step back from current coverage of these' services under the Medicare and Medicaid programs, as well as under many private health insurance plans. Coverage of rehabilitation services provided in hospital-based settings only would severely impede access to rehabilitation services for persons with disabilities, especially in rural areas. Moreover, such an approach promotes more costly institutional-based care over more cost-effective community-based care.

Coverage for personal assistance: The CCD recognizes and commends the Committee for calling together witnesses to discuss personal assistance for persons with disabilities in July of this year. What emerged from that hearing is the overwhelming consensus within the disability community that personal assistance services enable people with physical or mental impairments to increase their functional capacities. Access to such services is often time and resource-consuming, but should not be denied on this basis. Health care reform should facilitate access to these services.

Coverage for assistive technology: Many insurance plans use arbitrary distinctions between "medical necessity" and "functional necessity" to determine what types of assistive technology and services to cover. For example, wheelchairs are often considered as "durable medical equipment" while augmentative communication devices that would enable a person who can not speak to talk have been refused on the basis of arbitrary definitions of "medical necessity". CCD believes that health care reform should increase access to assistive technology which enables people with physical or mental impairments to increase their functional capacities.

Financing the public program AmeriCare: CCD is concerned that the viability of AmeriCare will depend on the limitations of state funding. One of the reasons that Medicaid provides such uneven coverage, uses low reimbursement levels, and imposes arbitrary eligibility criteria is that it depends on state willingness to fund basic health care services for the poor despite existing Federal mandates. As a result, there will be little political pressure on the Federal government to expand the basic health care package as part of AmeriCare which for the most part will cover the disenfranchised.

While the public plan in S. 1227 is not limited to persons with low income, it remains to be seen whether the public plan will have a tendency to replicate the inequities in the current Medicaid program. Whether AmeriCare will replicate this inadequate coverage of Medicaid may depend on who is covered by this public plan.

Reliance on cost-sharing: S. 1227 proposes to continue relying on cost-sharing as a strategy for cost containment. The problem with relying on deductibles to finance health care is that it penalizes higher users of health care while letting low users off the hook.

S. 1227 provides some relief for the poor and for high users of the health care system. It proposes to eliminate all cost-sharing for persons under 100 percent of poverty and to provide sliding scale subsidies for people with incomes between 100-200 percent of poverty in employer-sponsored private insurance plans or in the public plan. In addition, all persons are protected from catastrophic expenses above $3,000 per family for "covered services". Nevertheless, there is no subsidy or stop-loss available for health related expenses that are not covered by the insurance policy. CCD would support the inclusion of prescription drugs, durable medical equipment, home care and other related services in the catastrophic cap.

Practice guidelines: S. 1227 would expand the current emphasis on outcomes research to develop practice guidelines as a way to increase the effectiveness of the treatments that people get and reduce unnecessary health care. These practice guidelines would be used by third party payers to determine what services they should reimburse.

Although CCD supports goals of reducing unnecessary or duplicative costs, there are several problems with the use of practice guidelines from a disability perspective. One is that the complexity of a chronic health condition may preclude the development of a definitive set of recommended procedures.

Secondly, it will take a long time to develop practice guidelines for low prevalence health conditions when the current emphasis is on practice guidelines for high cost high prevalence conditions. It may be necessary for the Federal government to facilitate this process by providing financial support to professional associations and voluntary health agencies to try to arrive at a consensus about practice guidelines for specific conditions.

CCD is concerned that private insurers are increasingly using the excuse of "experimental procedures" to deny reimbursement for the best health care treatments available in order to maximize cost containment.

Quality Improvement Board: S. 1227 proposes the establishment of a Quality Improvement Board in each state to review the quality of health care provided by health care professionals and institutions, and to adopt guidelines for appropriate medical practice to improve the quality of care. Membership on the 15 member Quality Improvement Board in each state would consist of 7 representatives of health care providers, 4 representatives of insurers and purchasers of health care services, and 4 members of health care service researchers and consumers. But quality issues are too important a function to leave to providers and payers. It is crucial that persons with chronic health conditions have a major role on the quality improvement board.

Managed care: S. 1227 seeks to promote managed care by removing legal barriers to the operation of managed care and by establishing Federal standards for utilization review programs of health benefit plans. These Federal standards for managed care are very important because managed care can mean so many different things.

While managed care can provide the flexibility of financing and coordination of services that persons with disabilities sometimes need, we are also concerned that the promotion of managed care plans may jeopardize continuity of care for persons with disabilities who have medically fragile conditions. Protection of an individual's choice to select a non-managed care plan without financial penalty is critical to ensuring access to health care for persons with chronic health conditions. A major study must be proposed that would look at the implications of managed care and special needs populations.

Phase-in plan: Recognizing that some employers may not be able to contribute to the health insurance of their employees and dependents as soon as the law is

passed, S. 1227 proposes a phase-in plan designed to ease the pressure on small employers. While it may be reasonable to phase-in the employers' obligation, consumers should not be denied access to health care through the public plan before their employers are required to contribute to their health care.

Cost containment: S. 1227 proposes a Federal Health Expenditure Board to control health care expenditures. As long as the budget targets are only advisory, however, it is doubtful that expenditures will be contained or that sufficient incentives will exist to reallocate resources throughout the system. On the other hand, if an absolute ceiling on total national health care expenditures was set each year, it is not clear how this attempt at global budgeting would be imposed on a private health insurance system without jeopardizing access to health care for persons in the public plan.

CONCLUSION

The disability community needs to be a major player in reexamining health care financing policy. People with disabilities are highly vulnerable to the limitations of both public and private systems as they are squeezed between a private system which is designed to charge according to an assessment of risk and a public system which subsidizes health care according to age, poverty status, family structure, and an inability to work.

Private health insurance was developed and has remained a method for spreading risk of incurring excessive costs primarily for hospital and physician services. For individuals with disabilities, access to health care has been severely restricted because of preexisting conditions and the mistaken assumption that most people with disabilities need more hospital and physician care than the population as a whole. Health care reform needs to eliminate this restriction and assure access to needed hospital and physician services. Equally as important, the tradition of limiting covered services to hospital and physician services must be changed. Rehabilitation services, personal and support services, mental health services, and assistive technology must he recognized as essential components of health care.

Perhaps our greatest contribution will be in clarifying the principles which should guide our health care system. These include: (1) expanding the definition of "health" to include prevention services, rehabilitation therapies, assistive technology, and on-going health-related maintenance services; (2) distributing all health related expenses equitably throughout the population; and (3) restructuring our health care delivery system to more effectively support consumer-directed chronic care management.

Prepared Statement of the National Alliance for the Mentally Ill

National Alliance for the Mentally Ill,
Arlington, VA, August 14, 1991.

Honorable Edward M. Kennedy,
Chairman, Committee on Labor and Human Resources
United States Senate
Washington, D.C.

Dear Senator Kennedy: In any discussion of insurance reform from the point of view of advocates for the seriously mentally ill and their families, several standards are paramount. These standards are set forth as NAMI's criteria against which all universal access to health care reform bills are evaluated.

I. Access to affordable third-party health insurance coverage for all Americans at affordable levels of out-of-pocket expenses.

II. Coverage of disorders of the brain equal in scope and duration to coverage of all physical disorders.

III. By consequence, elimination of any arbitrary lifetime limitations on benefits payable for the treatment of mental illness.

IV. Coverage of all proven-effective modes of treatment—inpatient, outpatient, pharmacologic, case management, rehabilitative, and others appropriate to the individual's needs.

V. For persons dependent on the public sector (Medicare and Medicaid) coverage of mental illness benefits at least as comprehensive as presently available.

NAMI looks forward to working with you and your 'colleagues to bridge the gaps in insurance coverage for persons with serious mental illnesses. Enclosed please find

a background paper on health insurance for persons with mental illness for your review.

Sincerely,

KATIE VATH
President

BACKGROUND PAPER:

HEALTH INSURANCE FOR PERSONS WITH MENTAL ILLNESS

The dual system of care in the United States for persons with mental illnesses is, arguably, directly attributable to the lack of adequate health insurance protection to cover the costs of treatment services. Third-party payors typically cover treatment for "non-psychiatric" or "physical" illnesses in full or with minimal patient contribution, while excluding or otherwise limiting coverage of the treatment of mental (psychiatric) illnesses. The various industry-wide methods include: limiting hospital stays; setting annual or lifetime caps; placing high patient deductibles for outpatient care; requiring prior approval of treatment; and excluding certain coverage under pre-existing condition clauses.

Approximately sixteen percent of all working Americans are uninsured through their places of employment. Millions of others are either intermittently insured or grossly underinsured. For persons afflicted with a serious disabling condition, the problem is even more grave, beginning with finding a company willing to insure those who have disabling conditions. Over 1500 separate medical insurers operate in this country with very few offering satisfactory protection against the costs of rehabilitation and treatment.

For persons with private insurance, only one in three have inpatient mental illness treatment coverage comparable to inpatient coverage for other illnesses. Sixty percent of the privately insured have either fewer days of covered services or a special annual or lifetime dollar limitation on mental illness benefits. Only ten percent of the working insured are covered for partial hospital treatment. A mere six percent have coverage for outpatient mental illness services equal to outpatient services coverage for other illnesses. Arbitrary limits exist on the number of allowed visits, the total dollars a plan will reimburse, and/or the percentage of doctor charges paid. Most private insurance policies have severe "pre-existing" condition exclusions or limitations. Persons with serious mental illnesses are particularly impacted by these clauses, as mental illnesses often first occur and/or are treated during the late teen years and early adulthood. Many young persons find themselves in limbo—too old to continue coverage under their parents' policies and too young to be in the workforce where insurance is generally purchased. Companies utilizing this exclusion are, essentially, avoiding risks associated with insurance rather than managing this risk within the pool of insured persons.

Special coverage limitations on serious mental illness also exist in the two major public sector programs—Medicare and Medicaid. Medicare imposes a 190 day lifetime limit for care in a psychiatric hospital, but no such limits for care in the psychiatric unit of a general hospital. Outpatient psychotherapy services are covered without limitation on the number of visits, but still require a 50 percent of the dollar cost co-payment from the patient. Physician services—including medical management of mental illnesses—are covered without limitation on the number of allowed visits but with a 20 percent patient co-payment. In addition to persons over age 65, Medicare also covers persons with disabilities who have been on the SSDI rolls for more than two years.

Medicaid, by contrast, is a patchwork of 50 different health benefit programs. The federal government places few mandates on the states as to covered services. However, many states do not choose to offer "optional" benefits. For example, only 23 states provide rehabilitation services; 15 states provide personal care services, and 26 states provide case management. Persons aged 22-64 are not eligible for inpatient services in an institution for mental diseases (IMP) but are eligible for care in a general hospital. Less than half the states cover partial hospitalization, psychosocial rehabilitation, and day treatment or case management. Medicaid does, however, cover prescription drugs. For both Medicare and Medicaid, reimbursement rates to providers of services are so low as to effectively dissuade such providers from even "accepting" these patients. Hence, an inequitable and inefficient patchwork of programs and services is available to persons dependent on the public sector for health care services.

Recently, states have been much more responsive to growing constituent demands for better insurance coverage of mental illnesses. Actuarial data on the cost/benefits associated with coverage of the serious mental illnesses was instrumental in Texas, California, and Minnesota in convincing state legislators that treatment of mental illnesses is neither overutilized nor ineffective, and can be included in insurance coverage for a small additional premium. In Texas and California greater access to medical care has been achieved for persons with the most serious illnesses, and Congress should carefully examine the recent legislative developments in these two states. Here group health insurers who issue policies covering "disorders of the brain" are required to "offer" equal coverage of several severe mental disorders for which there is strong evidence of biological causes: schizophrenia, schizoaffective disorder, bipolar and delusional depressions, and pervasive developmental disorder. These new laws will remove the artificial barriers to seeking mental illness services and alleviate the severe financial drain on personal resources. In California, the Coopers and Lybrand accounting firm cost estimate proved that covering the costs of major mental illnesses is very modest when set against a large pool of insured persons. The new California law does restrict coverage for the other "mental health" benefits to 15 days per year for both inpatient and outpatient visits, thus in public policy differentiating on the basis of severity of illness. Legislation requiring parity coverage for state employees, higher education, school districting, city and county governments, recently became law in Texas, however only after exempting the private insurance industry from the law's requirements. Advocates will press for the inclusion of the private sector in subsequent legislative sessions.

As evidence of the sporadic pattern of private sector coverage of serious mental illness, by 1991 30 states had enacted insurance mandate laws with respect to minimum benefits which must be "offered" by companies selling insurance within the state borders. However, even in these states, the type and level of benefits mandated or offered vary widely: 25 states specify a minimum benefit for outpatient treatment (either a minimum dollar benefit, minimum number of visits or days, or a patient co-payment differential); 20 states specify an inpatient care benefit; 11 states require coverage of partial hospitalization; 11 states specify maximum patient copayments for outpatient treatment; 14 states apply the mandated benefits and/or offering laws exclusively to group policies.

While the responses from state governments may seem progressive from a public policy perspective, the American Psychiatric Association has identified three major shortcomings with this approach.

—13 of 30 states do not require coverage of treatment for mental illness, merely the offering;

—even in the other 17, the specified minimum benefits are still inadequate or discriminatory; and

—in 16 states, from 1990-91, minimum health benefits laws (not "mental health" mandates) have been enacted. These laws override or circumvent the mandated mental health benefit laws.

Also, it must be noted that these minimum benefit mandates do not pertain to employers who "self-insure," typically large employers. The federal Employment Retirement Income Security Act (ERISA) exempts self-insured employers from state mandates. S. 1227 overrides all state mandated benefit laws in lieu of a substitute federal minimum benefit requirement.

Senate Bill 1227, sponsored by Senators Kennedy, Mitchell, Rockefeller, and Riegle represents a gallant legislative effort to bridge the gaps for the 33-37 million persons without any health insurance coverage today. The establishment of a minimum "core" of health insurance coverage for working Americans is a bold initiative in the legislative journey to universal access to the highest quality health care available. The sponsors of the legislation must be commended for forbidding the health insurance industry from writing policies which exclude persons with "preexisting" conditions from seeking reimbursement for treatment services rendered for those conditions. This exclusionary underwriting has penalized persons with mental illnesses most severely.

While S. 1227 improves upon the currently flawed insurance market, NAMI can not endorse the bill as introduced. First, the legislation continues to differentiate between diseases of the brain and diseases affecting other organs of the body. Recent judicial and state legislative trends are finally moving in the direction of recognizing what science has been telling us for the past decade or more—that the biological and chemical underpinnings of schizophrenia and major affective disorders are identifiable, amenable to safe and effective medical treatment, and are as "physical" in origin as cancer or diabetes. Hence, these low-prevalence, medically managed illnesses must be recognized and reimbursed as diseases of the brain. This

legislation does begin to reflect research findings confirming a biological underpinning to many mental illnesses by requiring coverage of "medication management" visits to a physician, yet does not require unlimited hospitalization coverage for these same conditions. A forty-five day inpatient benefit, however, may not be sufficient for managing periodic episodes of psychosis or serious depression and serves to perpetuate stigma against psychiatric services. Including the most severe illnesses—as distinct from disorders of life which are amenable to psychotherapeutic interventions—at parity with the remainder of medical conditions could, surprisingly perhaps, be achieved at remarkably low cost for employers. The Coopers and Lybrand study of the California experience with requiring coverage of certain biologically-based conditions of the brain revealed a mere $0.78/per person/per month premium adjustment. This additional premium cost would even reduce further if computed against an even larger geographic pool of insured persons.

Second, while a uniform federal minimum standard for the 50 disparate public Medicaid programs is a concept which we endorse, the minimum mental illness benefits addressed in S. 1227 glaringly omit coverage of prescription drugs. Congress is well aware of the recent and ongoing public policy debate in this country regarding the new medication for the treatment of schizophrenia, clozapine, and the reluctance and refusal of state governments to cover the costs of this remarkable therapy, even with the tremendous cost-savings from reduced hospital care. Pharmacologic therapy is the treatment of choice for many of the consumers within our movement in keeping with the scientific and clinical revolution in managing a psychiatric illness. As such, S. 1227's omission of prescription medication coverage from the minimum insurance requirements is, we feel, a major shortcoming, and incompatible with one of our four cornerstone objectives—coverage for the continuum of services necessary to treat the serious mental illnesses.

Many health care economists surmise that the employer mandate to offer minimum health insurance will particularly impact the small business community forcing most to drop their existing coverage and instead pay the 7 percent payroll tax. We believe that the public program outlined in S. 1227 will be more heavily subscribed to than the bill's authors anticipate. Given that the majority of persons disabled by a mental illness are not regularly employed, it is imperative that the "public programs" cover at minimum the present scope of services. Any diminution in public sector benefits is unacceptable to NAMI.

NAMI will be carefully reviewing each of the federal legislative proposals introduced in the 101st Congress and commenting, when appropriate, on their respective strengths and weaknesses.

Prepared Statement of Glenn Plunkett, Governmental Relations Specialist, Governmental Relations Department, The American Foundation for the Blind

The American Foundation for the Blind is pleased to offer this statement for the record in the hearing of July 31, 1991 before the Committee on Labor and Human Resources on Health America (S. 1227).

The mission of the American Foundation for the Blind is to enable persons who are blind or visually impaired to achieve equality of access and opportunity that will ensure freedom of choice in their lives. AFB accomplishes this mission by taking a national leadership role in the development and implementation of public policy and legislation, informational and educational programs, diversified products, and quality services.

The Foundation has long been an advocate for a national health insurance program that would provide access to care for all Americans, regardless of their ability to pay. The method or methods of payment for coverage, place of residence, race, age, or gender should not affect access to health care. Any legislation providing access to care should mandate that the populace be entitled to all medically necessary services, long-term care, physicians' services, prescription drugs, home and community-based services as well as rehabilitation and habilitation services.

Also, a mandated national health care system should provide a continuum of services which includes rehabilitation services, employment oriented or not, to assist individuals to make the most of their abilities. One example of the need for services which are not now provided as part of the Medicare/Medicaid system is the need for independent living services for the elderly blind. Currently, very few elderly blind people have access to low vision services, orientation and mobility training, and rehabilitation.

The Medicare/Medicaid programs do not cover the services noted because they are not considered "medical" in nature. For example, individuals who are blind and who break a limb, in an accident caused by that blindness, can receive occupational therapy and other therapy to help them use the limb again; they cannot, however, receive services under Medicare to teach them how to prevent breaking the limb again. Such services would help blind people maintain the ability to function independently and prevent possible institutionalization.

Younger blind individuals who have vocational potential are served through the Rehabilitation Act of 1973 but elderly blind people have extremely limited access through Title VII, Part C of the Act because of very limited funding for the program. Services provided to the elderly blind help them maintain independent lives in their home and community, lessening their dependence on more costly services.

The elderly population in need of the services indicated above is growing rapidly. The latest data developed by the American Foundation for the Blind (Nelson, K.A, AFB, 1991) show that the number of elderly people who are severely visually impaired more than doubled between 1960 and 1990 from 1,250,000 to 2,578,000. By the year 2030, the number will more than double again, to just under six million people (5,850,000, an increase of 125% over the number for 1990).

The establishment of a system for national health insurance, with access to care for all, would be less costly than the fragmented, partial system extant in the United States in which a great percentage of the population has no access to health care. With preventive care and rehabilitation/habilitation as part of a coordinated system, the demand for more costly medical intervention and services should lessen as the health of the population improves, and as people maintain their independence as long as possible.

As a corollary to the establishment of a national health insurance program to provide access to health care, there is a great need to ensure personnel to provide health care and allied health services. We note that S. 1227 includes some funding over the next five years for the creation of community health centers to provide primary care services in underserved areas. Unfortunately, the proposed legislation does not provide for an expansion of medical and allied health service personnel to adequately serve the U.S. population. The mere provision of "coverage" without a corps of medical and allied care workers to provide services does not provide "access to care."

We are disappointed that the S. 1227 does not include a system of actual access to care but proposes an "incremental approach" to coverage. As well, the proposed legislation would tie access to medical care for some to state programs and subject them to rules and regulations creating limitation of care based on state plans. Again, this would add administrative complexities and costs to a system rather than providing ease of access.

Prepared Statement of The American College of Rheumatology

The American College of Rheumatology (ACR) is pleased to provide a statement for the record to the Senate Labor and Human Resources Committee for their hearing to consider legislation to provide affordable health care and reduce health care costs.

The ACR is the world's largest organization of rheumatologists, both physicians and scientists, dedicated to the prevention, treatment and eventual cure of arthritis and the more than 100 types of rheumatic diseases.

The ACR thanks Chairman Kennedy (D-MA) and the Committee for taking a leadership role on this pressing social and economic issue. Our statement will focus on access to care via insurance reform, and long-term care insurance. While the latter is often treated separately from the former, we believe that any complete discussion of health care costs and insurance coverage must include both access to basic medical care and long-term care.

Background

An estimated 33 million Americans, including individuals with arthritis and other rheumatic diseases, have no health insurance. Many millions more are under insured. Access to insurance coverage and access to long-term care for the 37 million people with arthritis poses special problems. Pre-existing conditions and involvement of other organ systems such as arthritis, may preclude their ability to obtain coverage. Many group or employee insurance plans do not include coverage for long-term care at all. Indeed, a significant number of individuals with a disabling rheu-

matic disease are not employed, and as a result, do not have access tO group or employee insurance benefits. In addition, access to coverage for children with rheumatic diseases may also pose special problems, given that such access may be limited by the provisions of their parents' policies. Furthermore, some policies currently available include an "escape clause" which provides for capitations on expenditures by the insurer.

Currently, only about two percent of older Americans, and practically no one under the age of 65 have true private long-term care insurance. Others, unprepared to pay for long-term care services, risk facing impoverishment that will affect themselves, their spouses, and their children, due to limitations of the Medicaid program. The problem is complicated by the fact that most people do not realize that they are not protected against these potentially catastrophic costs through Medicare, Medigap policies, or traditional health insurance.

Recent studies indicate that most Americans would be Willing to pay more for long-term care coverage and improved access to health insurance. These same studies indicate that the uninsured use less medical care than the insured, and that they are less likely to seek care when ill. In the long run, their medical costs will be higher as care continues to be delayed. Currently, the total costs of all types of arthritis are over $25 billion each year, including medical costs and costs resulting from lost income and reduced productivity. As physicians, we are concerned that this situation will only become worse. Timely and quality health cafe should be available for all Americans.

Access to Care—Insurance Reform Proposals

As a physician group, totally involved in the care of patients with arthritis, we are committed to finding solutions which will ensure access to affordable health care for all Americans with these acute and chronic disorders. The College is a member of the Physician Organizations for Access to Health Care, and is committed to working with Congress and the Administration to achieve legislation embodying the following principles:

—Utilizing the traditional approach of employer-based insurance, employers should be required to provide health insurance to their employees and dependents with appropriate cost-sharing by employees. Provisions should be developed to ameliorate any negative impact this might have on small businesses, such as tax relief, subsidies, phased-in implementation, and risk pools.

—Medicaid must be both expanded and substantially improved, including the enactment of minimum eligibility and benefit levels, and incentives to enhance provider participation.

—For those who are not eligible for employer-based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provisions should be made for participation in a subsidized program with cost-sharing on a sliding scale premium basis.

—Health insurance programs, whether public or private, should provide access to basic physical and mental health benefits.

—Proposals to expand access must be accompanied by measures to appropriately and effectively control health costs. Such measures should promote more efficient use and delivery of health care, encourage better value and quality for the health care dollar and involve the participation of providers, consumers, insurers, and employers. (The ACR recently completed its first practice guideline on Lyme Disease in conjunction with the Infectious Disease Society, and is currently setting up an organizational process to develop further guidelines and outcomes analysis.)

The College is aware of the many efforts made by Congress in the recent past toward solving the access crisis in America. We urge Congress to continue these efforts in 1991, and beyond if necessary, so that comprehensive access legislation can be enacted without further delay.

Long-Term Care Strategies

How to provide and pay for long-term care for elderly and disabled individuals who can no longer live independently is one of the most pressing problems facing Americans today. And, as Individuals are living longer, the question of how to pay for extended nursing and home care for the disabled elderly becomes more urgent.

The College supports the following recommendations for organizing and financing long-term care for elderly and disabled individuals who cannot live independently:

—Coverage for long-term health care services should include various options such as hospital care, nursing home care, hospice care, home care, respite care and day care.
—Any program should present a variety of options—voluntary, private and public—to pay for long-term care. These should include medical IRA's, transfer of vested pension funds, tax-deferred interest on insurance premiums, home equity conversions, and modifications to Medicaid spend-own provisions, among others.
—The primarily social aspects of long-term care—long-term custodial or institutional care, and outpatient personal care—should be financed and accounted for separately from health care services as defined above.
—Patients with rheumatic and musculoskeletal diseases should have equal access to currently available chronic care to meet their specific needs.
—Long-term care financing should insure against the risk of financial destitution as a result of paying for the care of an individuals once they cannot exist independently, either physically or mentally.
—Consumer participation in private financing of long-term care should be encouraged through a variety of modifications to the tax law. Mechanisms should be developed to encourage individuals to purchase long-term care insurance, as well as for employers to offer such policies as part of employee benefit packages.
—Any program for financing long-term care should be available to individuals of all ages who are chronically ill or disabled and who may need long-term care.
—States should be encouraged to provide an environment for the development of innovative long-term care financing and delivery arrangements.
—Consumer information programs should be expanded to emphasize the need for pre-funding anticipated costs for long-term care and to describe the coverage limitations of Medicare, Medicaid and traditional Medigap policies.
—Coverage for long-term care should include provisions for medications and activities of daily living.
—Insurance policies for long-term care should not include "escape clauses" thereby guaranteeing insurability for eligible recipients.
—Eligibility for long-term care insurance should require certification by a physician.

As outlined above, long-term care includes medical, custodial, social and other support services for people who suffer physical or mental disorders causing functional limitation or disability and, therefore, who need assistance for an extended period to maintain or promote functional well-being. These services range from informal home care to institutional skilled medical care. Any legislative proposal for long-term care should include this wide range of services frequently used by people with arthritis.

Closing

On behalf of the College, we urge the Committee to take action on the vital issues of improved access to health care and long-term care. With regard to health care, we should work toward strengthening the existing insurance coverage we now have. In long-term care, we need to identify strategies to create the coverage that is currently lacking in our insurance system.

August 16, 1991

The Honorable Edward M. Kennedy,
Chair, Committee on Labor and Human Resources
Labor and Human Resources—Health Office
Washington, DC.

Attn: Ms. Darrel Jodrey

Dear Senator Kennedy: Below are our comments on S. 1227, the HealthAmerica bill. We appreciate being asked to submit written testimony on this important piece of legislation.

While we are pleased that the legislation includes mandatory coverage for certain preventive health benefits (mammography, pap smears, well-baby and well-child care), there are many other cost-effective preventive benefits not included. We would suggest that there should be a mechanism for determining on an on-going basis which preventive care benefits should be added or subtracted from the plan.

The size of the deductibles ($250 individual, $500 family) is of concern. For extremely low-income people, such a sizable deductible is a significant disincentive to

seek care. We would recommend that deductibles and co-payments be structured as a certain percentage of income, rather than a dollar amount. In this way, rather than creating barriers to seeking care which in the long run are counterproductive for the health of the patient as well as the system, inducements are created which encourage people to seek early care.

According to the legislation, waiting periods before coverage becomes effective could exceed 30 days, and could be 90 days or greater, if the employer, provides comparable coverage benefits at the end of the employment period. To the extent that coverage is allowed to be discontinuous, the benefits of universal coverage are negated.

Likewise, a phase-in of coverage over several years for pre-existing conditions delays giving care to those who most need it, not only impacting the patient's health, but ultimately costing the system more. It should be a priority to get those individuals with pre-existing conditions into adequate care as early as possible.

Throughout the section on managed care, reference is made to "efficiency." We must keep in mind that efficient care does not always equal quality care. Encouraging managed care means narrowing the choice of the consumer to managed care entities whose major motivation may be to save money rather than provide the best care. In addition, managed care moves us away from a system of free choice of providers, a change that is not particularly palatable to either patients or providers.

Title VII of the bill provides grants for the creation of community health centers to provide primary care services in underserved areas. There needs to be a complementary federal program of incentives to encourage physicians to practice in these underserved areas, such as medical student support or a loan forgiveness program for years of service.

The legislation talks about the use of practice guidelines, national standards, and technology assessment. We strongly supports research into effective care modalities. However, the legislation raises questions. Who will develop the practice guidelines and assess the technology? We would suggest that practice guidelines be developed by academic physician bodies, based on valid research. What will be the role of the medical community in developing the national standards? How do these standards relate to existing review mechanisms, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and existing state review processes?

The creation of quality improvement agencies raises several concerns. First, like the creation of national standards, we wonder how these agencies would interact with JCAHO and other bodies that are already in place to promote quality care. in addition, the one-year exemption on utilization review for providers of efficient, quality care, implies that providers will be spending a considerable amount of time being reviewed. Who will review all of these providers? The current design creates an image of huge numbers of providers spending so much time reviewing and being reviewed, that little time is spent in practice.

Who will represent providers before the Federal Health Expenditure Board?

The legislation calls for the Federal Health Expenditure Board to collect, analyze, and evaluate the efficiency and quality of disseminate date that will help consumers evaluate the efficiency and quality of individual providers. Who will determine the criteria for efficiency and quality What will the data be? An enormous, expensive system is of doubtful value. Do patients want to select an "efficient" doctor? If a patient prefers to see a physician who meets with them for one hour, will that be covered? In that case, how is "efficient" evaluated, and is it relevant? In our view, medical professionals should develop the standards and maintain the quality of the profession.

We support the proposal put forth by the American College of Physicians, which recommends a no-fault malpractice system with an administrative mechanism to determine injury and appropriate compensation, combined with a disciplinary system for physicians.

The bill proposes a new Agency for Health Care Policy and Research, to research ways to reduce the cost of health care. Research should be done on the value of health care instead of the cost. The reference in the summary of the legislation to the development of the DRG program may be entirely appropriate; however, the DRG program is hardly one of success, and surely not a model we want to emulate.

The phase-in of coverage for employees of small business represents an extremely slow phase-in of the program for the vast majority of workers in this country.

We are unclear what the bill requires of small businesses after the four-year phase in. If voluntary compliance of 75% of business exempts the remaining 25% from providing coverage, then coverage is not universal and does not protect those who need it.

Ninety-five percent of all employers have fewer than 50 employees, and approximately 50% of all workers are employed by companies with fewer than 50 employees. Therefore, the provision which allows new small businesses to make no contribution to or provision for coverage in the first two years may be necessary for the businesses, but the number of people affected is quite high. While some of the workers may he able to buy into the HealthAmerica plan, many others may not be able to afford coverage.

Again, we appreciate the opportunity to share our views on this important legislation. We hope you will call on us if we can provide additional information as development of a nationwide health plan progresses.

Sincerely,

Susan C. Stewart, MD
Co-Chair, Ad Hoc Comm. on Health Care Reform
American Medical Women's Association

Janet Freedman, MD
Co-Chair, Ad Hoc Comm. on Health Care Reform
American Medical Women's Association

Prepared Statement of The American Association of Nurse Anesthetists (AANA)

The American Association of Nurse Anesthetists (AANA) appreciates the opportunity to comment on S. 1227, "Health America: Affordable Health Care for All Americans". As the professional society that represents over 24,000 certified registered nurse anesthetists (CRNA's), which is 96 percent of all nurse anesthetists who practice across the United States, AANA wants to convey our strong commitment to improving the nation's health care system. We commend the sponsors of S. 1227 for their leadership in structuring this critical debate on health care reform.

The AANA believes that reform of the current health care system is necessary because as many as 37 million Americans do not have adequate health care coverage. For that reason, the AANA is one of the 45 national nursing organizations that have endorsed Nursing's Agenda for Health Care Reform, which calls for building a new foundation for health care in America while preserving the best elements of the existing system.

We firmly believe that every American should have access to quality, cost-effective health services, including anesthesia services. The AANA is proud of the fact that CRNA's currently provide access to quality, cost-effective anesthesia, particularly in rural areas. However, the ability of CRNA's to continue to contribute to affordable health care solutions, can only occur when marketplace competition allows them to work without unnecessary practice constraints.

ACCESS

CRNA's personally provide more than 65 percent of all anesthetics administered in the United States annually, according to a 1988 Center for Health Economics Research (CHER) study.

CRNA's are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capability.

COST-EFFECTIVENESS

There is mandated coverage and payment for CRNA services under the federal Medicare program and the Civilian Health and Medical Program of the Uniformed Services. In addition, under the Federal Employees Health Benefits program, claims for services provided by CRNA's receive the same consideration as claims for services provided by anesthesiologists. At present, 30 states require direct Medicaid reimbursement to CRNA's. Currently, approximately 12 states have mandated coverage and payment for CRNA services by private insurance plans. In addition, many private insurers in the remaining states voluntarily cover and provide payment for CRNA services. The AANA believes that mandating coverage and payment for CRNA services does not increase overall health care costs because anesthesia services are currently covered services under all of the above programs.

CRNA's have accepted mandatory assignment under Medicare. Anesthesiologists can balance bill Medicare beneficiaries; only approximately 30 percent of anesthesiologists are participating physicians.

MARKETPLACE COMPETITION

The AANA believes that consumers should have freedom of choice regarding which health care provider performs a service for them. In several states, there have been cases of physician-controlled or physician-influenced insurance companies attempting to restrict the provision of anesthesia by CRNA's. Insurance companies accomplish this by not voluntarily covering CRNA services, by adopting restrictive requirements regarding supervision of CRNA's, or by raising premiums for surgeons or obstetricians working with CRNA's. These types of practices by physician-controlled or physician-influenced insurance companies often raise serious antitrust issues. Some of these non-coverage decisions or restrictions have been adopted out of ignorance of the quality of care rendered by CRNA's. In other cases, non-coverage decisions or restrictions may have been adopted at the urging of anesthesiologists. This occurs most of the time when anesthesiologists serve on the board of directors of these insurance companies.

Marketplace competition demands that all health care providers be given the opportunity to provide services that they are legally qualified to provide. Enhanced competition can result in decreased costs to the consumer.

QUALITY OF CARE

CRNA's have administered anesthesia for over a century. All existing data, including the 1988 CHER study, demonstrate that there is no difference in anesthesia outcomes based on whether the provider is a CRNA or an anesthesiologist. There is no data to support the claim that anesthesia care provided by an anesthesiologist is of higher quality.

CRNA's working alone are involved in 97 percent of all types of cases regardless of procedural complexity. For example, four CRNA's in solo practice are involved in open heart surgery at Sacred Heart Medical Center in Spokane, Washington.

The Centers for Disease Control recently decided not to conduct a national study on anesthesia morbidity and mortality because anesthesia morbidity and mortality rates are so low that it was felt that a national study was not justified.

RECOMMENDED MODIFICATIONS TO S. 1227

The AANA is pleased that the definition of "physician services" under section 2713 (a) (10) includes professional services provided by a licensed advanced-practice nurse, such as a CRNA. However, we have concerns about the following three provisions in the bill:

(1) Section 2722(e) (2) states "Different Levels of Payments.—Nothing in this title of the HealthAmerica Act, shall prohibit a health benefit plan from establishing a different level of payments for reimbursement for different health care providers furnishing the benefits for the items and services described in this section.

AANA Response: Under the new Medicare Resource-Based Relative Value Scale (RBRVS) system, Congress has adopted a new Medicare payment policy that eliminates payment differentials for medical specialties involved in delivering services when the services provided are essentially the same. Anesthesia services provided by CRNA's are essentially similar to anesthesia services provided by anesthesiologists. Therefore, under a consistent use of the new congressional payment rationale, payment for CRNA and anesthesiologist services should be the same. Public policy equity demands that Congress should use the same standards when analyzing different types of health care providers. Consequently, there is no need for section 2722(e) (2) in the bill, as it is contrary to earlier congressional action in establishing the Medicare RBRVS system.

(2). Section 2722(e) (3) states "Health Care Providers. Nothing in this title or the HealthAmerica Act, shall be construed to require a health benefit plan to utilize any health care provider (or type, class, or category of health care provider) to provide benefits for the items and services described in this section that were provided by the plan before the effective date of this part, other than the health care providers being utilized by the health benefit plan on such effective date, except that this paragraph shall not apply to duly licensed or certified clinical psychologists (acting within the scope of State law) after the end of the 5-year period beginning on the effective date of this part. This paragraph shall not apply to plans offered under part C."

AANA Response: If an exception is going to be made for duly licensed or certified clinical psychologists, then marketplace competition demands that a similar exception be made for CRNA's. The AANA concurs that there should be deference to

State law, regulations and legal decisions regarding CRNA practice requirements, just as is envisioned for psychologists.

(3). Section 2722(f) states "Basis of Payment May Differ from Actual Charges.—The requirement of payment for services described in subsection (a) shall not prevent an employer from establishing a fee schedule or other basis of payment that is different from actual charges, but only if such fee schedule or other basis provides, pursuant to regulations of the Secretary, for payment at a level sufficient to achieve adequate access to services covered by the plan without additional out-of-pocket expenses for the covered service (but for copayments and deductibles permitted under section 2724).

AANA Response: As the primary providers of anesthesia services in rural areas, we would be concerned if an employer (that may be facing financial problems) is the ultimate arbiter of what payment is necessary to ensure quality or accessibility of health care. While it appears that the 11-member Federal Health Expenditure Board envisioned in the bill would have a key role in developing payment rates, it is unclear what role, if any, the Board would have in ensuring that employers established fee schedules that allowed adequate access to quality health services. Is it anticipated that the Board would have a role in rate-setting at the level.of the employer-proposed fee schedule? If the Board does not have jurisdiction at the employer-proposed fee schedule level, is it then acceptable for every employer to set a fee schedule without any Board oversight as to minimum payment rates?

The section notes that there would be some oversight regarding access under regulations of the Secretary. The AANA would be concerned if this is the only oversight mechanism because of the slowness of the federal regulatory process. For example, the January 1989 proposed CRNA fee schedule rule has still not been issued as a final rule by HCFA.

CONCLUSION

The AANA looks forward to working with the sponsors of S. 1227 and the committee to enact the necessary reforms in the health care system that will allow Americans to have access to quality, cost-effective health care, including anesthesia services. Thank you for giving consideration to our views on this issue.

Prepared Statement of The American Association for Counseling and Development

We thank you, Mr. Chairman and members of the Committee, for the opportunity to express our views on S. 1227, Health America: Affordable Health Care for All Americans Act. We commend all of the sponsors of S. 1227, and particularly Senators Mitchell, Kennedy, Riegle, and Rockefeller, for their leadership in recognizing the health and mental health care needs of all Americans.

The American Association for Counseling and Development (AACD) represents nearly 60,000 professional counselors, counselor educators, and human development specialists across the country and abroad. Our members provide mental health, rehabilitation, employment, and other counseling services in a variety of settings including community mental health centers, hospitals, schools and universities, hospices, agencies for older Americans, private practice, and other community-based organizations. Professional counselors are at the front lines delivering counseling and mental health services to individuals, families, and groups in need of such care.

AACD supports and encourages the concept of basic health benefits for all Americans and believes that all Americans are entitled to health care, basic preventive medicine, and mental health services, as well as access to the services of professional counselors. While our association recognizes that medical costs are rapidly increasing, we believe that it is even more expensive to have the most vulnerable members of our society unprotected by health insurance.

AACD emphasizes wellness and mental health and supports the notion that keeping people healthy and out of the health care delivery system is the best way to lower medical costs. We commend the sponsors of S. 1227 for their attention to the preventive health care needs of Americans, including pre-natal and well-baby care, well child care, and pap smears and mammograms for women.

Our association's themes during the last two years reflect our commitment to the concept of wellness. The 1990-91 theme "Wellness Throughout the Lifespan" has been followed by our current theme of "AACD: Building Societal Excellence," which, as described by AACD President Marianne H. Mitchell, Ed.D., NCC, "conveys our belief that a society's excellence is reflected by the degree to which its citi-

zenry can develop and enhance their human potential; their capacities for being productive, healthy, happy and caring individuals.

The approach taken by S. 1227 represents good, feasible national health policy. For an industrialized nation as rich as the United States to have 37 million Americans—including 12 million children—without adequate or regular access to health care, is a national disgrace.

S. 1227 would begin to address the health care gaps in our country by guaranteeing 23 million workers and their families access to a minimum package of health care benefits through their workplace. For the non-working uninsured population, these individuals would be covered through a public program—AmeriCare—which would replace the current Medicaid program. We applaud the overall objectives and concepts framed in S. 1227.

Many of AACD's members provide mental health services in settings ranging from community-based organizations to private practice. With regard to the mental health coverage (and substance abuse coverage) outlined in S. 1227, our organization believes that there are several provisions in the legislation which are beneficial to people who need health services:

—coverage of 45 days of inpatient hospitalization and 20 visits to a qualified mental health professional for psychotherapy.
—permission to "trade off" between days of hospitalization and outpatient visits, as long as the insurance plan provides a combination of inpatient and outpatient care—in order to encourage the use of the least restrictive treatment setting based on the needs of the patient.
—prohibition on insurance carriers from excluding people from coverage due to pre-existing health and mental health conditions.
—enhancement of access to services by permitting a broad range of licensed or certified mental health professionals operating independently or in clinics to provide mental health care.
—a requirement that all insurance plans cover the basic mental health benefit package outlined in the legislation.

AACD is particularly pleased that the services of qualified professional counselors would be permitted under S. 1227. The bill states that outpatient psychotherapy and counseling for a mental disorder can be provided by a duly licensed or certified mental health professional. The 1988 Committee on Labor and Human Resources Report on S. 1265 (Report 100–360), states that "an individual who possesses a master's degree, has completed two years of supervised clinical experience, is licensed or certified by a state regulatory agency or is eligible for recognition by a relevant professional body, and provides outpatient therapy or counseling to individuals, couples, and families shall be deemed an 'equivalent mental health professional.' "

The profession of counseling has established entry level criteria to ensure that service providers have the necessary skills to provide services to clients.

AACD is concerned that S. 1227 provides less coverage for the treatment of mental health problems (and substance abuse problems) than for physical health ailments. We believe there should be equity in the treatment of mental health benefits and physical health benefits under any legislation addressing the health care needs of Americans.

Our organization believes that insurance coverage should be designed to ensure that all individuals have access to a mental health benefit, including treatment for substance abuse, that does not inappropriately limit care. Because many of AACD's members provide psychotherapy and counseling on an outpatient basis, we are concerned that a maximum of 20 outpatient visits does not allow for enough coverage for beneficiaries who may have more extensive needs. However, because our organization has been involved in the development of, and negotiations on, certain components of this legislation over the last few years, we are aware that it may not be feasible at this time to increase the minimum benefit level of 20 outpatient psychotherapy visits.

With regard to state mandate laws on health insurance, an adequate national mandated minimum benefits law is preferable to a patch work of state mandate laws. Less than half the states have any law at all, and half of these simply require that health insurance plans offer mental health benefits, not require them. We would like to see states which have laws mandating health insurance coverage that are broader than the requirements in S. 1227, to have the ability to supersede the federal mandate.

Certain groups of professional counselors within our association practice in the fields of rehabilitation and aging. An additional benefit which would be extremely important for people with disabilities—mental or physical—would be coverage for

prescription drugs. We are pleased to see that S. 1227 authorizes a study addressing the feasibility of covering prescription drugs, and we will be monitoring the progress and results of this study.

Psychosocial rehabilitation services is another benefit which should be part of a national health care policy. A psychosocial rehabilitation benefit would entail a program of rehabilitation services focusing on the development of independent living and vocational skills. Such programs have been found to be cost-effective in providing community care to adults with serious mental illness and other disabilities.

Case management services help to ensure that an individual receives the appropriate range of support services necessary to function in society.

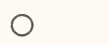
In the rehabilitation area, this may include coordination and follow-up on services by a qualified rehabilitation professional, vocational evaluation, assessment, and placement. In the mental health area, such supports may include mental health treatment, income, and housing, among others. Individuals should have access to case management services to help ensure that an adequate treatment plan is developed, implemented, and coordinated.

We commend Health America: Affordable Health Care for All Americans Act for its comprehensive and universal approach to the acute care, outpatient physician services, diagnostic care, and short-term mental health needs of our nation's citizens. Furthermore, we applaud the sponsors of S. 1227 for eliminating the discriminatory process of pre-existing condition clauses.

Though our concerns regarding limits on mental health services, lack of coverage for rehabilitation services, and the absence of long-term care coverage for older Americans and people with disabilities (we understand future legislation will be introduced to address a national long-term care policy) are real, we will stand behind legislation such as S. 1227. This bill could serve as a stepping stone to future health care reform efforts and will begin to address some of the serious health care needs of the 37 million people who have no physical health, mental health, or rehabilitation coverage at all.

The American Association for Counseling and Development congratulates the committee for its efforts in reforming our health care system. We look forward to working closely with the committee toward the achievement of universal access to comprehensive health care for all Americans.

[Whereupon, at 1:25 p.m., the committee was adjourned.]



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